Ian Wardle
MANAGING DIRECTOR

Civic Offices, Bridge Street,
Reading RG1 2LU
☎ 0118 937 3787

To: All members of the Health & Wellbeing Board

(Agenda Sheet to all Councillors)

Our Ref:
Your Ref:

Direct: ☎ 0118 937 2112
e-mail: nicky.simpson@reading.gov.uk

9 July 2015

Your contact is: Nicky Simpson – Committee Services

NOTICE OF MEETING – HEALTH & WELLBEING BOARD – 17 JULY 2015

A meeting of the Health & Wellbeing Board will be held on **Friday 17 July 2015 at 2.00pm in the Council Chamber, Civic Offices, Reading.** The Agenda for the meeting is set out below.

AGENDA

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5. PRESENTATION ON READING YOUTH CABINET'S CAMPAIGNS ON MENTAL HEALTH AND PSHE 13

Apoorva Sriram, Manasi Panshikar and David Totterdale will give a presentation on Reading Youth Cabinet's campaigns on Mental Health and PSHE (Personal, Social, Health & Economic) education.

6. BERKSHIRE WEST PRIMARY CARE STRATEGY 2015-19 24

A copy, for review by the Health and Wellbeing Board, of the Berkshire West Clinical Commissioning Groups' 5 Year Strategic Plan, which describes how, by 2019, enhanced primary, community and social care services in Berkshire West will work to prevent ill-health within local populations and support patients with complex needs to receive the care they need in the community, only being admitted to hospital where this is absolutely necessary.

7. SOUTH READING & NORTH & WEST READING QUALITY PREMIUM TARGETS 2015/16 61

A report on the South Reading and North and West Reading Clinical Commissioning Group (CCG) Quality Premium Targets for 2015/16 and seeking formal approval of the six targets.

8. IMPROVING SUPPORT TO THE EX-GURKHA COMMUNITY: ACCESS TO AND EXPERIENCE OF HEALTH AND SOCIAL CARE SERVICES IN READING 69

A report presenting a report by Healthwatch Reading on an engagement project they undertook in 2014 with the ex-Gurkha community in Reading, to find out how they access and experience health and social care services. The report also sets out Healthwatch Reading's recommendations to care commissioners and providers and their responses.

9. HEALTHWATCH READING ANNUAL REPORT 2014/15 92

Healthwatch Reading's second annual report, giving details of the work carried out by Healthwatch Reading in 2014/15.

10. INTEGRATION UPDATE 112

A report giving an update on the Health and Social Care Integration Programme, including an analysis of the guidance on the Health and Wellbeing Board's responsibility for monitoring and reporting on Better Care Fund performance; information on the revised Non Elective Admissions to hospital (NEL) target submitted to NHS England on 15 May 2015; and an update on the Discharge to Assess scheme.

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11. UPDATE REPORT ON INFORMATION SHARING WORK BEING TAKEN FORWARD BY THE LSCB 118

Further to Minute 5 (4) of the last meeting, when it had been reported that a key factor in keeping children safe is the effective sharing of information, an update report on the progress of the LSCB (Local Safeguarding Children Board) Information Sharing Task and Finish Group working on reviewing the existing Information Sharing Protocol and producing a revised document.

12. READING CHILDREN'S TRUST CHILDREN AND YOUNG PEOPLE'S PLAN 2015-2018 120

A report presenting the Reading Children's Trust's latest Children and Young People's Plan (2015-18) which sets out the expectations the Trust has in priority areas identified as issues for children and families in Reading, which has been endorsed by the Adult Social Care, Children's Services and Education Committee.

13. DATE OF NEXT MEETING -

Friday 9 October 2015 at 2pm

14. DATE OF JANUARY 2016 HEALTH AND WELLBEING BOARD MEETING -

It has been discovered that the Health and Wellbeing Board meeting agreed at the last meeting to be held on Friday 29 January 2016 will clash with a health workshop due to be held on the same date. It is therefore proposed that the Health and Wellbeing Board meeting is moved to Friday 22 January 2016.

READING HEALTH & WELLBEING BOARD MINUTES – 17 APRIL 2015

Present:

Councillor Eden	Lead Councillor for Adult Social Care, Reading Borough Council (RBC)
Councillor D Edwards	RBC (substituting for Councillor Lovelock)
Councillor Gavin	Lead Councillor for Children's Services & Families, RBC
Councillor Hoskin (Chair)	Lead Councillor for Health, RBC
Lise Llewellyn	Director of Public Health for Berkshire
David Shepherd	Chair, Healthwatch Reading
Ian Wardle	Managing Director, RBC
Cathy Winfield	Chief Officer, Berkshire West Clinical Commissioning Groups (CCGs) (substituting for Andy Ciecerski)

Also in attendance:

Gabrielle Alford	Director of Joint Commissioning, Berkshire West CCGs
Caroline Ainslie	Director of Nursing, Royal Berkshire NHS Foundation Trust
George Boulos	Clinical Lead, North & West Reading CCG
Debra Elliott	Director of Commissioning, NHS England (South Central)
Pat Leroy	Service Manager - Improvement, RBC
Sally Murray	Head of Children's Commissioning Support, Berkshire CCGs
Jean O'Callaghan	Chief Executive, Royal Berkshire NHS Foundation Trust
Melanie O'Rourke	Interim Head of Adult Care, RBC
Caroline Penfold	Disability Service Manager (Adults & Children), RBC
Rob Poole	Corporate Finance Business Partner, RBC
Nicky Simpson	Committee Services, RBC
Chris Stevens	Inclusion Services Manager, RBC

Apologies:

Andy Ciecerski	Chair, North & West Reading CCG
Wendy Fabbro	Director of Adult Care & Health Services, RBC
Frances Gosling-Thomas	Independent Chair, West Berkshire, Reading and Wokingham Local Safeguarding Children Boards
Vicki Lawson	Interim Head of Children's Services, RBC
Councillor Lovelock	Leader of the Council, RBC
Helen McMullen	Interim Director of Children, Education & Early Help Services, RBC
Maureen McCartney	Operations Director, North & West Reading CCG
Eleanor Mitchell	Operations Director, South Reading CCG
Ishak Nadeem	Chair, South Reading CCG
Asmat Nisa	Consultant in Public Health, RBC
Councillor Stanford-Beale	RBC
Suzanne Westhead	Interim Director of Adult Care & Health Services, RBC
Sarah Wise	CCG Manager, North & West Reading CCG

1. MINUTES

The Minutes of the meeting held on 30 January 2015 were confirmed as a correct record and signed by the Chair.

2. ROYAL BERKSHIRE NHS FOUNDATION TRUST CQC IMPROVEMENT PLAN

Further to Minute 3 of the last meeting, Jean O'Callaghan and Caroline Ainslie submitted a copy of a presentation giving an update on progress on the Royal Berkshire NHS Foundation Trust's Care Quality Commission (CQC) Post Inspection Action Plan, as well as a copy of the latest CQC Action Plan, following the CQC Inspection in March 2014.

It was explained that, following the CQC formal inspection on 24–26 March 2014, after which the Trust had been awarded an overall rating of 'Requires Improvement', a lot of work had been done on the seven 'Compliance Actions', details of which were set out in the presentation slides. The Trust had just had its one year annual review of progress, and the Action Plan set out the progress which had been made and next steps. The seven Compliance Actions covered the following areas:

1. Treatment of disease, disorder or injury - Surgical procedures
2. Treatment of disease, disorder or injury - Diagnostics & Screening (radiology)
3. Treatment of disease, disorder or injury – Privacy & Dignity
4. Treatment of disease, disorder or injury - Maternity & Midwifery premises
5. Treatment of disease, disorder or injury – Consent
6. Treatment of disease, disorder or injury - Staffing
7. Medical Records

Caroline Ainslie addressed the Board on the progress made. She noted that, in line with a national problem with recruitment and retention of medical and nursing staff, the Trust had similar ongoing challenges. The Trust had robust processes in place to monitor progress, which was reported publicly in Trust Board meetings, there was monthly reporting on planned versus actual numbers of nurses, and systems were in place to keep appropriate resourcing levels. The incidence of "Never Events" had reduced significantly in the last year and it was now 130 days since the last never event. Staff training on the Mental Capacity Act, Deprivation of Liberties and Dementia had improved and there had been big improvements made in medical records and maternity services, although there was still work to do.

In response to a query about the number of red and amber actions in the plan, she explained that, although there were still a number of actions rated amber, this was because the Trust was reluctant to change actions from amber to green unless it had assurance tested at the point of care delivery that the issue had been completely resolved. At the year end review, a clear need to devolve ownership to ward level had been identified, and a number of the actions featured in various improvement programmes across the Trust. The CCGs were scrutinising the Trust in detail as commissioners, visiting on a regular basis to do Quality Assurance visits and ensure progress against actions, as well as challenging the Trust at monthly and quarterly meetings.

Cathy Winfield confirmed that the CCGs were working closely with the Trust on monitoring progress of the Action Plan and said that the CCGs had confidence in the quality of services being provided; the CCGs were able to compare providers and on a number of issues, such as hospital acquired infections, the Trust compared very well with others. The CCGs were also assured about nursing at the Trust, despite staffing problems, and she noted that the Trust was looking at creative ways of improving the situation.

The meeting noted the ongoing challenges for the Trust, including dealing with its budget deficit alongside increasing demand for services, and it was suggested that, whilst it was good for the Trust to be cautious about changing actions to green, it might be helpful for the Trust to communicate more clearly about the progress being made to show the public what was being done.

Resolved -

(1) That the position be noted;

(2) That the Board's thanks to all the staff at the Trust for their hard work whilst facing difficult challenges be recorded.

3. READING INTEGRATION – UPDATE REPORT

Melanie O'Rourke and Cathy Winfield submitted a report giving an update on a number of key areas of work within the Health and Social Care Integration Programme as it related to Reading. This included an update on the following Better Care Fund schemes, their progress and plans for implementation:

- Hospital @ Home
- Enhanced Support to Care Homes
- Berkshire West Connecting Care (Interoperability)
- Discharge to Assess / Time To Decide beds
- Whole System / Whole Week (Neighbourhood Clusters, Health and Social Care Hub and 7 day working)

The report stated that, as part of the NHS planning process, the two Clinical Commissioning Groups (CCGs) in Reading had developed refreshed "Plans on a Page" and had submitted drafts of these to NHS England. The report provided a summary of the updated Reading CCG priorities, many of which related directly to the Integration Programme.

The report also gave details of work being carried out on the development of the Frail Elderly Care Pathway, noting that a Frail Elderly Steering Group had been established with senior leadership across the West of Berkshire to drive forward the development of a model, which it was anticipated would create greater opportunities for integration beyond those already in place.

The report explained that, in reviewing the second year of the local CCG operating plans, NHS England had advised the CCGs to revise the target for reducing Non Elective Admissions to hospital (NEL) for 2015 – 2016. The need to revise the target related to the pressures experienced over the winter period, alongside now having a clearer understanding as to how the Better Care Fund schemes were likely to impact on NEL activity. The report set out the progress that had been made in determining a new target.

The report explained that the two Reading CCGs had reviewed their most recent non elective (NEL) admission data during the process of reviewing and refreshing their Two Year Plans as requested by NHS England. This had then revised the baseline denominator from which the % change in activity was calculated. The calculations had included, as previously, all those improvement intervention schemes which were expected to have an impact on reducing NEL activity, including the Better Care Fund,

but also schemes that had been directly commissioned by the CCGs, such as the community respiratory service.

On 27 March 2015, Health and Wellbeing Board members had been contacted via email for their views on revising the target for reducing Non Elective Admissions to Hospital (NEL) for 2015 – 2016 from 2.8% to 0.6%. As the timing for submission of the draft target had not coincided with a Health and Wellbeing Board meeting, it had been necessary to seek "in principle" agreement by Board members outside of the scheduled meeting, prior to formal approval at the meeting. An email had been sent out to Board members on 27 March 2015, seeking such approval. No adverse comments had been received from Board members.

However, since that point, further analysis of the data had been conducted to secure an accurate and realistic figure. It was important that the impact both financially for the whole system and against capacity and service delivery were considered and any areas of risk identified and mitigated where possible.

It was explained at the meeting that the initial work had been based on data from the early part of the year and that, once the December 2014 and January 2015 data had been received, showing that there had been a lot of NEL due to flu and respiratory problems, NHS England had advised that the target in the BCF had been too aspirational and high risk to use in the following year. It was noted that the four CCGs were already in the top five in the South of England regarding having low NELs, and also that, whilst the Hospital at Home work was reducing admissions, these were still technically counted as admissions as people attended hospital for assessment, even though they were discharged on the same day. There was an upward rise in NEL and the aim would now be to reduce this trajectory, rather than actually reduce NEL. Further work with all partners was needed to model this area, and to come up with an ambitious but realistic target. It was therefore proposed that the Board authorised the Director of Adult Care & Health Services to agree a new target, in consultation with the Board members, so that it could be submitted by the NHS England final submission deadline of 14 May 2015. The final agreed target would be reported to the next Board meeting.

The report also stated that NHS England had issued guidance "Better Care Fund: Guidance for the Operationalisation of the BCF in 2015-16" on 20 March 2015, which set out the reporting and monitoring requirements for the Better Care Fund, and how progress against conditions of the Fund would be managed. Officers were undertaking work to determine the implications of these requirements and a further report would be brought to the next Health and Wellbeing Board to advise the Board of its obligations.

Resolved -

(1) That the following be noted and supported:

(a) the progress which had been achieved in taking forward Reading's Better Care Fund schemes;

(b) the priorities set out in the Reading Clinical Commissioning Groups' Two Year Plan refresh;

(c) the further development of the Frail Elderly Pathway;

(2) That the work that had been undertaken, and the work that was required, to develop a revised Reading Better Care Fund performance target in relation to Non Elective Admissions for 2015-16 be noted;

(3) That the Director of Adult Care & Health Services be authorised, in consultation with the voting members of the Health and Wellbeing Board, to agree a revised Reading Better Care Fund performance target in relation to Non Elective Admissions for 2015-16 for submission to NHS England by 14 May 2015, and the final agreed target be reported to the next meeting;

(4) That the receipt of guidance from NHS England "Better Care Fund: Guidance for the Operationalisation of the BCF in 2015-16" be noted and a further report on this be submitted to the next meeting.

4. PRIMARY CARE UPDATE REPORT

Further to Minute 4 of the last meeting, Cathy Winfield and Debra Elliott submitted a joint report which provided an update on primary care in Reading following the discussion at that meeting.

The report described changes to commissioning arrangements which would enable the CCGs and NHS England to work together to implement their emerging strategy for primary care. This strategy would set out how they would work to address current challenges facing the local primary care system in order to ensure its future sustainability as a key component of an enhanced out-of-hospital sector. The report set out the following new key 'asks' of primary care services that would be in the strategy:

- Managing the health of a population in partnership with others. Identifying patients at high risk of admission or ill health and working proactively with others in primary, community and social care to put in place co-ordinated care plans to support patients at home;
- Interfacing in new ways with specialisms historically provided in secondary care to manage increasingly complex chronic disease in a community setting;
- Ensuring appropriate access to primary care services in line with patient need. Offering extended provision to improve access and better meet the needs of patients requiring urgent care thereby ensuring patients got optimal care without needing to go to hospital;
- Making effective referrals to hospital when people would most benefit.

The report described work undertaken to identify practices that might currently be facing particular pressures in order to work with them to address those challenges and plan for the future. It also gave information on national and local work to address the specific challenge of GP recruitment and retention.

The report also provided an update on current issues which had previously been highlighted to the Health and Wellbeing Board. It described progress following the publication of the Care Quality Commission (CQC) report for Priory Avenue Surgery and highlighted the publication of further CQC reports for Reading practices. It also provided an update on a forthcoming procurement exercise relating to the Reading

Walk-in Centre and on the interim provider arrangement now in place at the Circuit Lane Surgery.

It was reported at the meeting that it was hoped to conclude discussions on the plans for Priory Avenue Surgery in the next few days and then the interim provider could be announced; all parties would be informed and communication plans were in place to advise patients.

It was confirmed at the meeting that one of the six practices in South Reading CCG inspected by CQC, the Melrose Avenue Surgery, had been put in Special Measures as it had been rated inadequate. NHS England were working closely with and providing support to the partners involved, one of whom was currently in hospital. Lise Llewellyn also reported that the Council had set aside money to work with Berkshire Healthcare NHS Foundation Trust and the local community on the future of this surgery.

Resolved - That the report and position be noted.

5. LETTER FROM MINISTERS REGARDING SHARING INFORMATION EFFECTIVELY FOR THE PROTECTION OF CHILDREN

Pat Leroy submitted a report on a joint letter from Government Ministers, dated 3 March 2015, which had been sent to all Chief Executives, Directors of Children's Services, Local Safeguarding Children Boards and Health and Wellbeing Boards following the publication of the Government response to the child sexual exploitation cases in Rotherham, and which stated that a key factor in keeping children safe was the effective sharing of information. The letter was appended, as well as a list of 'Eight Golden Rules of Information Sharing' which had been disseminated to frontline staff.

The letter stated that local areas should consider the following principles for multi-agency working:

- Integrated working (eg co-location) – Close collaboration in multi-agency working was essential in developing 'real time' risk assessments to enhance decision making. A truly integrated approach helped to break down cultural barriers, leading to greater understanding and mutual respect among different agencies.
- Joint risk assessments – these ensured clear and sufficient information about particular cases and joint plans for individual interventions.
- A victim-focused approach – the needs of the victim must be at the forefront of approaches, not systems and processes.
- Good leadership & clear governance – strong leadership could often bind different organisations together to develop a shared culture.
- Frequent review of operations – to continue to drive improvement of service.

The report stated that the letter had been discussed at the Reading Local Safeguarding Children Board (LSCB) on 5 March 2015, and actions had been agreed to review the existing Information Sharing Protocol and produce a revised document in time for the next LSCB meeting on 14 May 2015.

The report asked the Health and Wellbeing Board to note the contents of the Ministers' letter, sign up to the principles it contained and note the actions set by the

LSCB. A further report would be produced for the July 2015 Health and Wellbeing Board to update on progress.

Resolved -

(1) That the content of the Ministers' letter be noted;

(2) That the Board sign up to the principles of multi-agency information sharing set out in the letter;

(3) That the actions taken by the LSCB be noted;

(4) That a progress report be submitted to the next meeting.

6. STATUS REPORT ON COMPREHENSIVE CAMHS (CHILDREN & ADOLESCENT MENTAL HEALTH SERVICES)

Gabrielle Alford submitted a joint report giving an update on service development and improvement across the CAMHS (Children & Adolescent Mental Health Services) system.

The report explained that there were serious and deeply ingrained problems with the commissioning and provision of CAMHS, nationally, regionally and locally, and explained the reasons for this. It stated that a comprehensive engagement exercise had been completed about the Berkshire CAMHS service in spring 2014, which had resulted in ten recommendations for improvements. A joint action plan had been developed, providing a range of commitments to improve the service delivery to meet the recommendations, and the report gave details of progress made to date, including work going on currently to refresh the part of the Joint Strategic Needs Assessment which described CAMHS, as well as future opportunities for further improvements.

The report had appended:

- Appendix 1 – acronyms used in the report
- Appendices 2 & 3 – Definitions and examples of Tier 1 to 4 CAMHS services commissioned in Berkshire
- Appendix 4 – Reading Action Plan to improve Comprehensive CAMHS service delivery

The report proposed that the Children's Trust Board should oversee implementation of the Action Plan and hold partners to account, and suggested that progress on the Action Plan should be reported at future Health and Wellbeing Board meetings on a six-monthly basis.

It was reported at the meeting that, since the report had been written, the CCGs had agreed an additional £1.5m funding for investment in CAMHS in 2015/16, £1m of which would be recurrent. The CCGs were also talking to NHS England about the possibility of pooling budgets so that savings made in Tier 4 caused by improvements in Tier 3 could be used to re-invest in Tiers 1 and 2.

It was also reported that, although it had been announced that the Government was committed to spending £250m a year over the next five years on CAMHS, it was not yet clear what that would mean in terms of specific funding. However, £250k had

been put into early intervention in pyschosis and it was expected that the £150m funding for treatment for eating disorders announced in December 2014 would be allocated through a bidding process for populations of around 750k, so partners were working together to prepare appropriate bids.

The meeting discussed the importance of early diagnosis and intervention, and of redesigning the care pathways to enable joining up of services, in order to improve the CAMHS service.

Resolved -

(1) That the progress made in terms of strategic direction and service improvement be noted;

(2) That the Board provide partnership commitment to the Action Plan that aimed to build a transformed comprehensive and integrated full CAMHS service offer to families;

(3) That the JSNA be improved in its analysis and recommendations for CAMHS;

(4) That responsibility for overseeing the implementation of the Action Plan be delegated to the Children's Trust Board, and the Health and Wellbeing Board receive an update report every six months on progress.

7. READING'S AUTISM STRATEGY

Caroline Penfold submitted a report on a proposed Autism Strategy, which set out plans to improve support for children, young people and adults with autism in the Borough. The report had appended a draft version of the Strategy along with an Equality Impact Assessment.

The report explained that, in 2013, Berkshire Autistic Society had been commissioned by the Council to complete an assessment of the needs of people with autism in the borough, and the services available to support children, young people and adults with autism and their families and carers. The report had been informed by a consultation with people with autism and their families, mapping of existing provision in Reading, and an examination of population projections and data to understand need.

Progress on the research by Berkshire Autistic Society, including initial findings, had been reported to the Health and Wellbeing Board on 13 December 2013 (Minute 45 refers) and the Board had agreed to a future report on the Autism Strategy once completed.

The Berkshire Autistic Society research had been used to develop an Autism Strategy for children, young people and adults with autism in Reading. The Strategy set out the national and local context for people with autism and their families, and the current service provision. The main part of the Strategy presented six priorities for improving support for people with autism in Reading:

1. Increasing awareness and understanding of autism
2. Improving access to diagnosis
3. Supporting better outcomes for people with autism

4. Supporting people with autism to live safely and as independently as possible
5. Supporting families and carers of people with autism
6. Improving how we plan and manage support

Work was under way to produce an Action Plan that set out how the actions identified in the Strategy would be delivered and it was proposed that the multi-agency Strategy Steering Group which had overseen the development of the Strategy continued to meet to oversee this work, as an Autism Partnership Board.

Resolved -

(1) That the Autism Strategy be approved and recommended for sign-off to Council and other partners;

(2) That the establishment of an Autism Partnership Board to progress work on the Strategy through an Action Plan be endorsed;

(3) That the Strategy Action Plan be presented to the Board at a future meeting.

8. UPDATE ON CHANGES TO SEN PROVISION 2014-16

Further to Minute 19 of the Adult Social Care, Children's Services & Education (ACE) Committee meeting held on 6 November 2015, Chris Stevens submitted a report setting out the progress that had been made by the Council, schools and parents in the development of a proposed Special Educational Needs (SEN) Strategy Action Plan and in meeting the required statutory duties. A copy of the SEN Action Plan was attached to the report at Appendix A.

The report gave details of how the statutory requirements set out in the Children and Families Bill for September 2014 had been met, including the publication of the Local Offer. An SEN Strategy Action Plan had been co-produced with parents and school representatives, setting out the direction of travel for officers, schools and parents to follow. The report stated that this might require further decisions to be taken at policy level, which would be reported to the ACE Committee as necessary.

Conversion plans to Education, Health and Care (EHC) Plans for children with Statements of Special Educational Needs were under way to meet the appropriate timetable and the report gave further details of progress to date and planned next steps in relation to SEN provision.

Resolved -

(1) That it be noted that the statutory requirements set out in the Children & Families Bill for September 2014 had been met, including publication of the Local Offer;

(2) That it be noted that the SEN Strategy Action Plan had been co-produced with parents and school representative, setting out the direction of travel for officers, schools and parents to follow.

9. TRANSFER OF 0-5 COMMISSIONING RESPONSIBILITIES – HEALTH VISITORS/FAMILY NURSE PARTNERSHIP

Rob Poole submitted a report that set out the contracting arrangements for the transfer of the Health Visiting and Family Nurse Partnership Service.

The report explained that the transfer of the commissioning responsibility to the Council for the Public Health 0-5 years Health Visiting and Family Nurse Partnership Service had been progressing steadily both nationally and locally. The national allocations of the resource had been confirmed and work had progressed to agree the service specification that would be provided from 1 April 2015. The first six months for 2015/16 would be commissioned by the NHS England Area Team and from 1 October 2015 the Council would become responsible for commissioning these services.

In order for the Council to deliver its responsibility from 1 October 2015 it had been working with the Public Health Shared Team and the NHS England Area Team to review the national specification and make adjustments for local variations. This work was progressing and to support it the Council was required to state its contracting intentions. The proposals for both the Health Visitor and Family Nurse Partnership Service were set out in the report.

The report set out progress to date on the transfer and contracting arrangements and gave details of the decisions made by the Adult Social Care, Children's Services and Education (ACE) Committee on 4 March 2015 to agree the contracting approach for the two services and to authorise the Director of Children, Education & Early Help Services to enter into the contracts by 1 April 2015.

The meeting noted the importance of there being work within the Health Visiting Service's Healthy Child Programme for 0-5s on emotional health and wellbeing as well as physical health and wellbeing.

Resolved -

(1) That the progress to date in terms of development and agreement of the Health Visitor and Family Nurse Partnership service specification and contract be acknowledged;

(2) That the decisions made by the Adult Social Care, Children's Services and Education (ACE) Committee on 4 March 2015 to agree the contracting approach for the two services and to authorise the Director of Children, Education & Early Help Services to enter into the contracts by 1 April 2015 be endorsed;

(3) That the Board endorse continuing with the existing partnership working processes to ensure a safe transfer of 0-5 commissioning responsibilities.

10. WEST OF BERKSHIRE SAFEGUARDING ADULTS PARTNERSHIP BOARD ANNUAL REPORT 2013-14

Melanie O'Rourke submitted a report providing a summary of the information contained within the West of Berkshire Safeguarding Adults Partnership Board (SAPB) Annual Report 2013-14, a copy of which was attached to the report at Appendix 1.

The report explained that the SAPB Annual Report 2013-14 provided an overview of the Board's activity and progress during 2013/14 and its priorities for 2014/15. The data within the report had been sourced from the statutory Abuse of Vulnerable Adults (AVA) return for 2012-13.

The report summarised the key developments in 2013-14, performance in 2013-14 and the priorities for 2014-15.

Resolved - That the contents of the West of Berkshire Safeguarding Adults Partnership Board (SAPB) Annual Report 2013-14 be noted.

11. DATES AND TIMES OF FUTURE MEETINGS

Resolved –

That the meetings of the Health & Wellbeing Board for 2015/16 be held at 2.00pm on the following dates:

- Friday 17 July 2015
- Friday 9 October 2015
- Friday 29 January 2016
- Friday 18 March 2016

(The meeting started at 2.00pm and closed at 4.15pm)

READING BOROUGH COUNCIL

HEALTH & WELLBEING BOARD **17 JULY 2015**

PETITION in accordance with Standing Order 36.

Lead Petitioner: Paul Farmer

Petition wording:

"1. Without any local NHS community Child & Adolescent Mental Health (CAMH) services/staff being commissioned at weekends (even emergency services/staff) Berkshire's young folk with mental health issues (and their families) are still being left to face all crises alone.
2. Without any local specialist NHS CAMH services/staff being commissioned, Berkshire's under 16 year old victims of sexual abuse/rape (despite a confirmed increase of 40% in reported UK cases in 2014 – The professional body for policing) and their families are still being left to face the many (and long-term) mental health traumas associated with child/adolescent sexual abuse/rape alone (it has recently been officially acknowledged that over 75% of all adult mental health problems first surface during childhood or adolescence and 25% as a direct result of childhood or adolescent sexual abuse or rape – the Independent Mental Health Task Force Study 2014/15).
3. Also only 78 full time equivalent community NHS CAMH staff are still being commissioned for Berkshire (the same level as year end March 2000!!!) – despite acknowledged increases in demand each year since 2000!

So, please sign our petition for:

a) Expert NHS Support at weekends for Berkshire's young folk with mental health problems, and for the ever rising numbers of victims of childhood/adolescent sexual abuse/rape in Berkshire; and for
b) More NHS community staff/services for Berkshire's young folk with mental health problems in general and help try to take away their fear and isolation and help try to increase the commissioning of NHS services/staff which support them across Berkshire.

Further notes/points:

The National Institute for Health and Care Excellence (in Jan 15) estimated that:

a) £44m a year could be saved by supporting young folk with mental health problems as soon as they surface – thereby preventing adult mental health problems and/or psychiatric hospitalisation!
b) That 1 in 20 A&E cases were caused by mental health cases - the majority of which surfaced during the individual's childhood or adolescence!
c) The Princes Trust (in 2015) has revealed that 1 in 9 of the UK's young folk are emotionally or sexually abused at home and as a result twice as likely as their peers to suffer mental health problems."

Reading Youth Cabinet

Campaign Presentation

Apoorva Sriram, Manasi Panshikar, and David Totterdale

An introduction to our campaigns

- PSHE
  - Database for teachers
  - Poster Campaign to raise awareness
- Mental Health
  - Borough-wide survey
  - Improved awareness/knowledge of the specialist school nurse service.

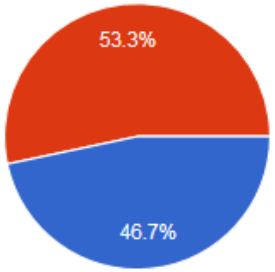
MENTAL HEALTH

Mental Health Survey Results:

Have you had any assemblies or PSHE lessons about mental health?

Assembly	**71**	26.2%
PSHE lesson	**131**	48.3%
Neither	**116**	42.8%

Are you aware of a specialist school nurse?



Yes	**126**	46.7%
No	**144**	53.3%

Wednesday lunchtimes.
I don't know.
don't know
Wednsdays
dunno
we have had an assembly but it was really short
On a Wednesday
Lunch on a Wednesday

YOUNGMINDS

The voice for young people's **mental health and wellbeing**

'There is considerable stigma associated with mental health.'

'It has been found that providing young people with lessons on mental health in school improves attitudes to mental health'- Young Minds PSHE response review

What we aim to achieve

- Increase awareness of services available to young people i.e. specialist school nurse
- Increased school support- especially through P.S.H.E and assemblies
- Increased student input into mental health education
- Increased funding to school nurse services
- Feedback

P.S.H.E.

YOUNGMINDS

The voice for young people's **mental health and wellbeing**

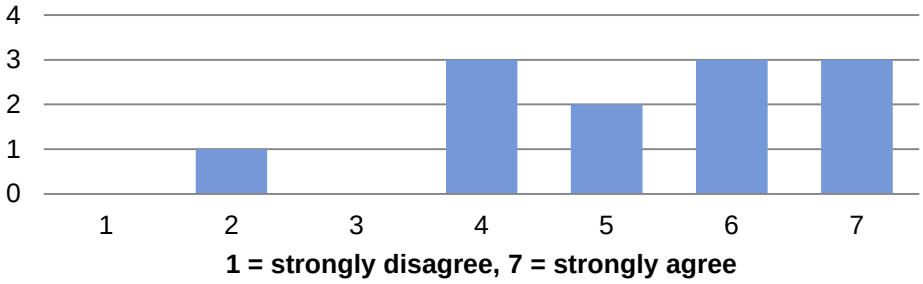
"We believe that PSHE should complement the wider curriculum and ensure that young people have a rounded education that equips them to cope with everyday life and their development into adulthood."

Academic qualifications are important, but young people also need to develop emotional resilience, life and social skills

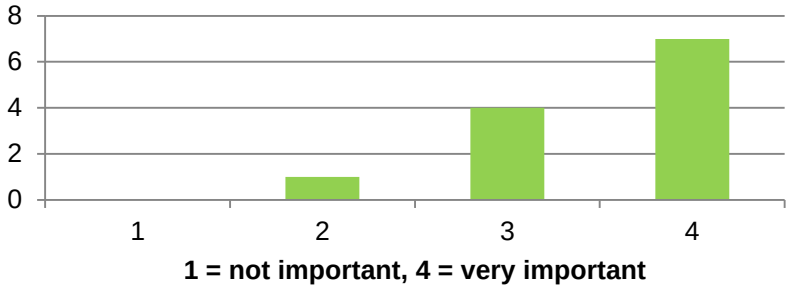
PSHE- Evidence

Teachers

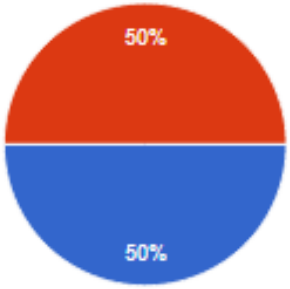
Would you like more PSHE resources to be available to you?



Do you regard PSHE as an important subject, in comparison to other subjects, e.g. Maths?



Have you had training for teaching PSHE?



"Not at all, I have had no formal training to teach what can be quite delicate subjects. I rely largely upon my own life experience and knowledge. A subject like this requires specialisation."

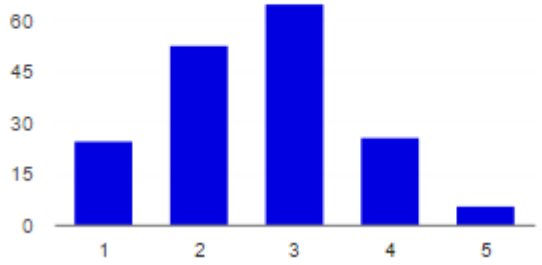
- Given in response to the question "**Do you think you've been given sufficient training in dealing with the issues raised by PSHE lessons?"**

PSHE- Evidence

Students

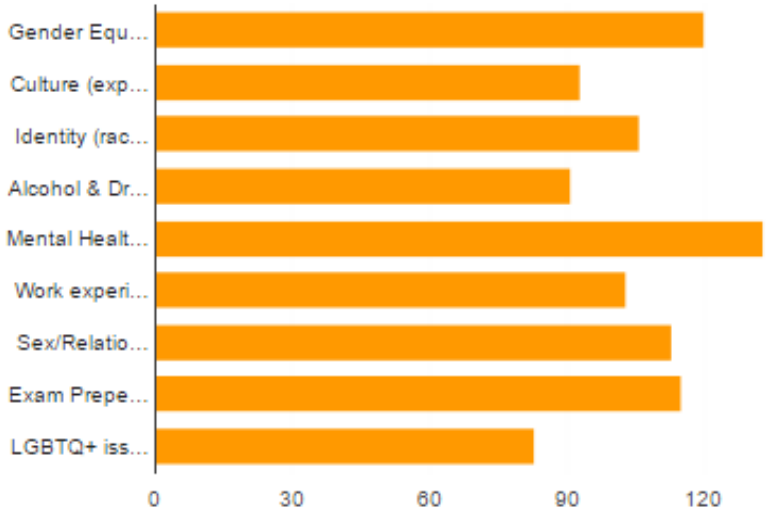
https://docs.google.com/forms/d/1M_4cy0UN4rjRcJkE-8gjNb0oF59bme8-uXcZ9Gij4po/viewanalytics

Overall, how would you rate PSHE in terms of effectiveness?



1 = ineffective, 5 = very effective

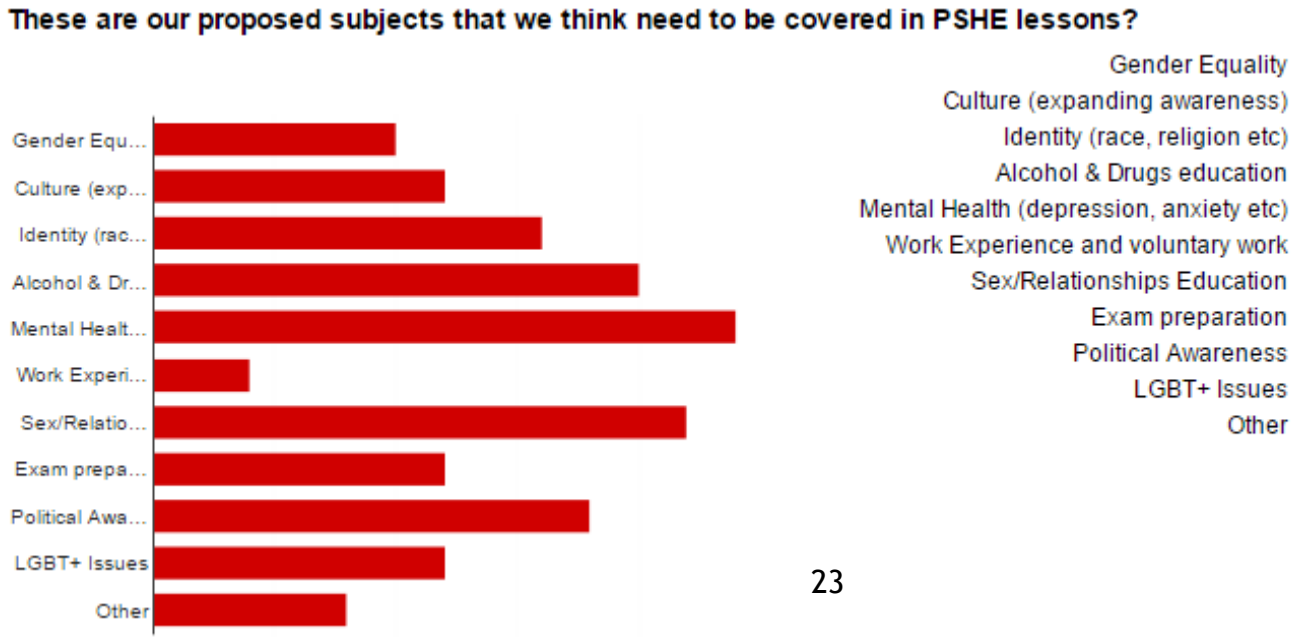
Here are the main topics that we think the PSHE curriculum should cover, which ones do you agree with?



Gender Equality	**120**	68.6%
Culture (expanding awareness)	**93**	53.1%
Identity (race, religion etc.)	**106**	60.6%
Alcohol & Drugs Education	**91**	52%
Mental Health (depression, anxiety, stress etc.)	**133**	76%
Work experience and Voluntary work	**103**	58.9%
Sex/Relationships Education	**113**	64.6%
Exam Preperation	**115**	65.7%
LGBTQ+ issues	**83**	47.4%

Aims

- Create an online databank of resources
- Give guidance to teachers about sensitive subjects, and to show them a young person's viewpoint
- Write lesson plans focused on the subjects that young people want to learn about



Berkshire West Primary Care Strategy

2015 – 2019

DRAFT

1. Introduction

The Berkshire West CCGs 5 Year Strategic Plan describes how, by 2019, enhanced primary, community and social care services in Berkshire West will work to prevent ill-health within our local populations and support patients with complex needs to receive the care they need in the community, only being admitted to hospital where this is absolutely necessary.

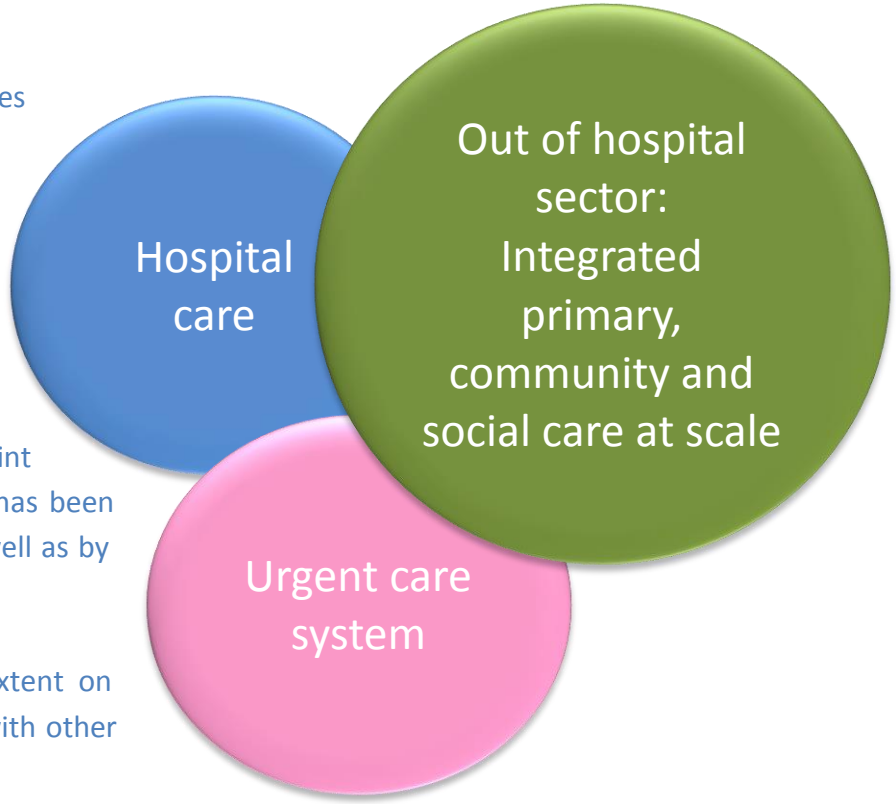
The overriding aims of our overarching Berkshire West CCGs plan which underpin this strategy are:

- Placing a greater emphasis on prevention and putting patients in control of their own care planning.
- Moving away from disease specific services to the commissioning of person centred care.
- Implementation of new models of care which support better integration, and which expand and strengthen primary and out of hospital care.
- Development of new payments mechanisms which incentivise the delivery of outcome focused care and which support the future sustainability of the local system.
- Development of urgent and emergency care networks which ensure patients get the right care at the right time in the right place.
- Better use of technology and innovation to achieve better outcomes for patients and improved demand management.
- Achieving parity of esteem for people with mental health problems and learning disabilities.

Over the coming year we will be exploring options for the development of locally appropriate models of care which offer innovative solutions to support delivery of these objectives in the context of the Five Year Forward View (NHS England October 2014), addressing both the financial challenges facing our system, and the increasing demand for services.

This Strategic Plan builds upon the overarching CCGs Strategic Plan by describing a more detailed vision for Primary care service in Berkshire West; anticipating that Primary care will play a pivotal role in delivering new models of care and in ensuring the sustainability of the broader health and social care system in the light of increasing demand and financial pressures.

This Strategy also describes what we intend to do to address the current challenges facing the sector including financial issues, growing workload pressures and increasing challenges in recruiting and retaining GPs and other key healthcare professionals.



The Strategy has been jointly developed by the four Berkshire West CCGs working together with NHS England as the statutory commissioners of primary care services, and with patients and partners (see Appendix 1). Its development has been overseen by our joint Primary Care Programme Board (shortly to become the Joint Primary Care Co-Commissioning Committee, membership listed at Appendix 2) and has been guided by a Task and Finish Group including GPs, Practice Managers and Nurses, as well as by discussions in each of the four GP Councils.

At this stage the Strategy focuses on primary medical services, and to a lesser extent on community pharmacy, but the opportunities and importance of integrated working with other community services is also a key theme.

Implementation of the Strategy will be overseen by the Joint Primary Care Co-Commissioning Committee, linking with the CCGs' other Programme Boards as appropriate. The Terms of Reference for the Joint Primary Care Co-Commissioning Committee are available at INSERT HYPERLINK.

2. Our Vision for Primary Care

By 2019, primary care in Berkshire West will be:

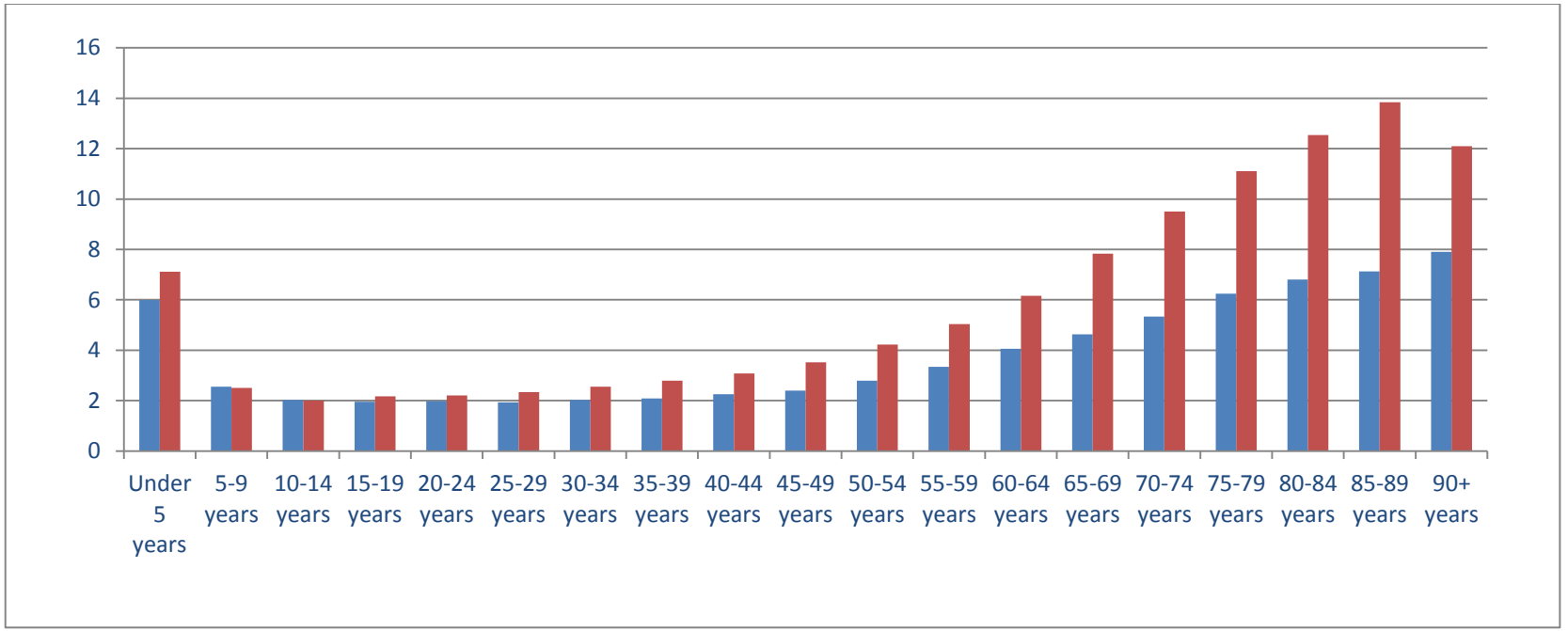
3. The Case for Change

There are 55 GP practices in Berkshire West, providing care to 550,000 patients from 77 surgeries. For 2014-15, the total budget for general practice services in Berkshire West was £64.9m, made up of £59.1m NHS England funding for contractual payments including QOF and enhanced services, and £5.8m invested by the CCGs in community enhanced services including Admissions Avoidance (care planning for Over 75s), support to care homes, early identification of diabetes and extended hours.

All practices in Wokingham CCG and all but one in Newbury and District CCG hold GMS contracts. In North and West Reading and South Reading CCGs, the majority of practices hold PMS contracts. There are currently four APMS contracts in place in Berkshire West, one of which includes a Walk-in Centre component and two of which are one-year interim contracts held by Berkshire Healthcare NHS Foundation Trust (BHFT). All four contracts are therefore due for re-procurement within the next two years. Out-of-Hours services are provided by Westcall (part of BHFT).

The quality of primary care provision in Berkshire West is generally high. The CQC's Intelligent Monitoring System (GP Intelligent Monitoring : Care Quality Commission) brings together data from the Quality and Outcomes Framework, EPACT prescribing data, GP patient survey results and Hospital Episodes Statistics (HES) to rate GP practices from 1-6 according to levels of variance from national norms. Currently the vast majority of Berkshire West practices are rated as either Band 5 or 6 (where Band 6 signifies the lowest level of risk). It is however recognised that there is some variation in performance against the indicators measured and a small number of practices were prioritised for an earlier CQC inspection based on this data.

It is becoming increasingly evident that pressures affecting the wider UK primary care system are starting to impact upon Berkshire West practices. The national increase in consultation rates, reflecting an ageing population increasingly suffering from one or more long-term conditions (see Figure 1, below), is being replicated in Berkshire West where over the 2014-15 Winter period, practices reported a 25% increase in consultation rates when compared with the previous year.



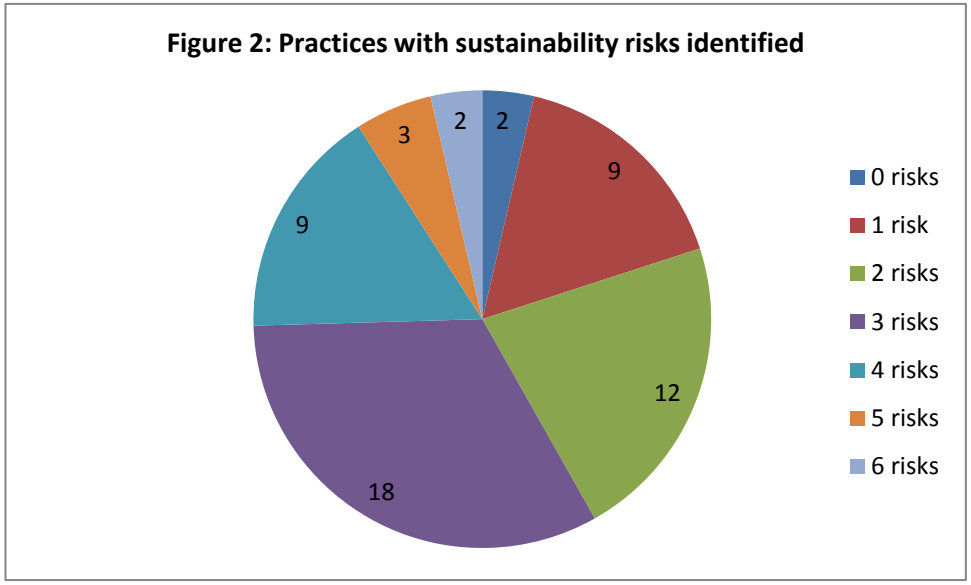
Changes in consultation rates 1995-2008 (HSCIC)

A further pressure relates to GP recruitment and retention. The Royal College of General Practitioners (RCGP) reports that the number of unfilled GP posts has quadrupled in the last three years and that applications to undertake GP training have dropped by 15%.[1] The Nuffield Trust reports that a third of GPs aged under 50 are considering leaving the profession in the next five years due to workload pressures.[2] There is an increasing trend towards part-time posts with 12% of general practice trainees now working in this way and towards salaried employment with just 66% of GPs now working as partners compared to 79% in 2006.[i] 27 of the 55 Berkshire West practices have indicated that they are currently experiencing issues with recruiting GPs and other

[1] http://www.rcgp.org.uk/news/2014/october/over-500-surgeries-at-risk-of-closure-as-gp-workforce-crisis-deepens.aspx
[2] *Is Primary Care in Crisis?*, The Nuffield Trust, November 2014

clinical staff and with a high proportion of Berkshire West GPs and Practice Nurses aged over 50 these issues are expected to become more acute over time.

Patients have told us that they are generally happy with the standard of care provided but would like services to be better co-ordinated so that they only have to 'tell their story once'. Some feel that access to GP services could be improved, particularly by surgeries being open in the evenings and at weekends, but patients also recognise that they need to play a role by accessing services appropriately and considering self-care for minor conditions. Patients would welcome being supported to take a greater role in their care and also believe that primary care could work more effectively with other organisations including in the voluntary sector to promote health and wellbeing. Further information about the priorities identified through patient engagement, together with details of how these are reflected in the Strategy are included in Appendix 1.



The CCGs have recently undertaken a 'risk mapping' exercise aiming to assess the stability of the CCGs' GP practices in order to work with them proactively to address risks and avoid potential contract failures. In addition to recruitment and retention and workload pressures associated with serving a deprived or growing population, this took into account CQC risk ratings, practice size, condition of premises and the potential financial impact of NHS England's review of PMS contracts and phasing out of the Minimum Practice Income Guarantee currently paid to some GMS contractors. Eight measures were considered in total and Figure 2 summarises the level of 'sustainability risks' identified. This data will now be triangulated with quantitative data from other sources such as the national Primary Care Web tool, other CCG reporting tool and demographic information with a view to establishing an ongoing mechanism for identifying and responding to risks associated with primary care contracts.

Both NHS England's *Five Year Forward View* and our own Strategic Plan highlight the importance of a strong primary care sector working at the heart of integrated care provision for patients within the community. But to play this role it is recognised that primary care will need to change, working at scale to overcome current challenges and interfacing with other organisations in new ways.

The remainder of this document describes the strategic objectives and key workstreams which will enable us to realise our vision for primary care.

4. Strategic objectives

In order to deliver our vision, we have set the following five strategic objectives for primary care:

- Addressing current pressures and creating a sustainable primary care sector.
- Interfacing in new ways with specialisms historically provided in secondary care to manage increasingly complex chronic disease in a community setting.
- Managing the health of a population in partnership with others. Acting as accountable clinicians for the Over 75s and other high risk patients and co-ordinating an increasingly complex team of people working in primary, community and social care to support patients at home.
- Offering extended provision to improve access and better meet the needs of patients requiring urgent care. Using new approaches to ensure access to primary care in line with patient need.
- Making effective referrals to other services when patients will most benefit.

The following sections describe in more detail the models of care that we intend to develop in relation to each of these strategic objectives or 'asks' of primary care. In delivering these models, we will also address other aspects of our vision, such as ensuring that primary care in Berkshire West is sustainable, cost-effective and an attractive place to work, and that patients value the services provided and are supported to access them appropriately.

Strategic Objective 1: Addressing current pressures and creating a sustainable primary care sector.

Innovative solutions will be employed to address the challenges currently facing the primary care sector. We will work to address the current workforce crisis at all levels; improving pre-registration training provision, improving job satisfaction through more rewarding continuing professional development opportunities and working to improve retention of mid-career GPs and others by working with practices to offer more varied and flexible employment opportunities. We will also look to maximise the potential of new roles in primary care including Physicians' Associates, practice-based pharmacists and enhanced administrative and care co-ordination roles. Alongside this we will work to enable practices to respond to demand in new ways (see Strategic Objective 3) and to ensure that the expansion of the role of primary care is accompanied by an increase in primary care investments (see Strategic Objective 2).

Digital systems are the foundation upon which we will build a modern, efficient and responsive primary care sector. Enabling information to flow between care providers within and beyond organisational boundaries, and between care providers and patients, is a key means by which we will achieve a sustainable primary care sector. GP IT systems sit at the heart of primary care technology facilitating and recording thousands of interactions with patients every week. GP practices have led the way in the move from paper to digital record-keeping and recently begun offering online transactions, such as appointment bookings, repeat prescriptions, and online access for patient to their GP- held records.

In a challenging financial environment, IT services must not only improve the quality of care through enhancing the patients' experience of services, but also enable the practice to realise efficiency benefits such as a reduced administrative burden. Building on the solid foundations which are already in place in primary care, our vision is to support practices to develop IT functionality which responds to the evolving needs of patients and underpins integration across care pathways.

It is our view that addressing workforce challenges, capitalising on IT developments and providing the models of care set out under the following strategic objectives will require primary care providers to operate at scale. Single-handed and small practices are unlikely to be able to provide the range and

breadth of services described, or manage the communication and relationships required to operate as part of a truly integrated system. Similarly investment in IT and premises infrastructure is only likely to be cost effective where it serves a large patient population. Going forward, our intention is therefore to make commissioning and investment decisions that support the development of providers with at least 6,000 registered patients, and ideally 10,000 or more. There is evidence that encouraging the emergence of larger providers is likely to result in sustainable provision and improved outcomes for patients going forward.[3]

Strategic Objective 2: Interfacing in new ways with specialisms historically provided in secondary care to manage increasingly complex chronic disease in a community setting

Existing community-based care pathways, such as that developed for diabetes, will form the starting point for expanding similar models to other specialties. Virtual outpatient clinics and community-based consultants will become the norm and technology will be used to maximum effect to support self-care and timely liaison between clinicians working in primary and secondary care. Where additional services are commissioned from primary care, the associated investment must follow.

The implications of providing a greater range of services in primary care must be fully factored in to all levels of workforce and premises planning. Larger primary care providers will be better placed to take on expanded roles, and in any case collaboration will be required so that specialists can interface across practices.

[3] *Securing the future of general practice: new models of primary care,* Nuffield Trust and the King's Fund (2013)
Primary Care: Today and tomorrow – Improving general practice by working differently, Deloitte Centre for Health Solutions (2012)
Breaking Boundaries – a manifesto for primary care, NHS Alliance (2013)
Primary Care for the 21st Century, Nuffield Trust (2012)
Does GP practice size matter?, Institute of Fiscal Studies (2014)

Strategic Objective 3: Managing the health of a population in partnership with others. Acting as accountable clinicians for the Over 75s and other high risk patients and co-ordinating an increasingly complex team of people working in primary, community and social care to support patients at home.

Primary care should work as part of the broader health and social care system to avoid patients going into crisis and requiring emergency admission and to support effective discharge from hospital. Proactive care planning for patients with complex needs who may be at risk of admission, including those in care homes, will be further developed to become a core element of primary care provision. A multidisciplinary approach will be taken, with technological solutions supporting the sharing of care plans so that patients only have to 'tell their story' once and different organisations can work together in a co-ordinated way to meet their needs.

Primary care will take a more active role in working to improve the health of the population it serves. Practices will provide more primary and secondary prevention services, linking extensively with public health, the voluntary sector and other community organisations to prevent ill-health and promote wellbeing.

Supporting the broader health and social care system will be our programme for information sharing and connecting the health and social care system - "Connected Care". This has already commenced with the introduction of static interoperability, between practices and Out of Hours primary Care, but over the next 18 months practices will join a wider dynamic programme connecting, practice systems, with acute, community and social care system.

Strategic Objective 4: Offering extended provision to improve access and better meet the needs of patients requiring urgent care. Using new approaches to ensure access to primary care in line with patient need.

New technology will enable practices to respond to demand in different ways such as through greater use of the telephone, online consultations and email advice systems (with safeguards in place to ensure these systems are used appropriately), as well as technology enhanced mobile working. Patients will be supported to self-care where appropriate and to access the right services at the right time. Community pharmacy may also play a greater role in providing advice and guidance to patients.

The CCGs will encourage practices, especially smaller ones, to work together to respond to same day requests for appointments in a different way, thereby freeing up time for staff to focus on planning care for at-risk patients and on managing long-term conditions. The potential for NHS 111 to take an enhanced role in managing same day demand will be explored through the forthcoming re-procurement process.

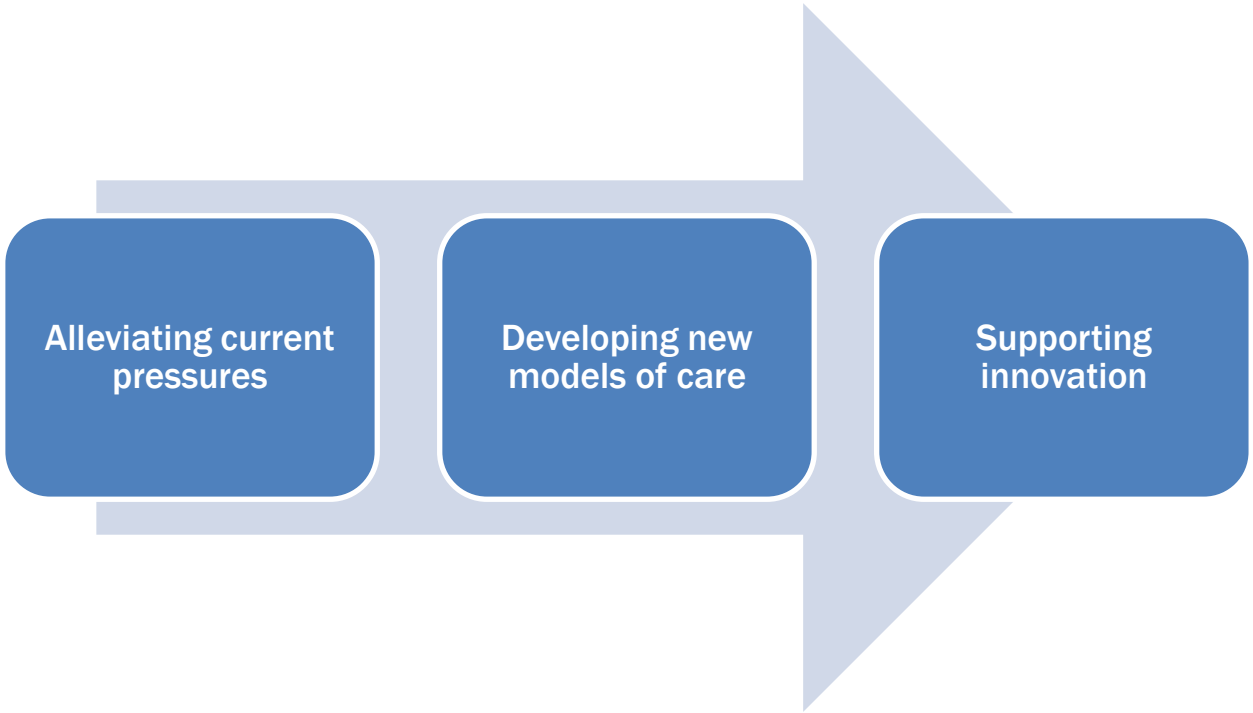
Primary care will function as a key component of the urgent care system and primary care providers and practices will therefore be commissioned to provide more appointments in the evenings and on Saturday mornings and potentially at peak times in-hours. By also providing bookable appointments within these sessions we will improve patient experience and avoid patients attending other services inappropriately outside of core hours. It is likely that practices will increasingly work together to meet demand for same day appointments, possibly through 'hub and spoke' arrangements. In developing such hub arrangements, the CCGs will have regard to the principles set out in the Keogh Review of ensuring patients have access to the right advice or treatment, in the right place and at the right time and the likely emergence of the 'Urgent Care Centre' model.

Strategic Objective 4: Making effective referrals to other services when patients will most benefit

The CCGs will work with practices through peer review and closer liaison with secondary care colleagues to reduce unexplained variation in levels of referral between practices and individual clinicians, thereby ensuring that patients are referred to the services that will most benefit them and at the most appropriate stage of their treatment. Support to referrals will be strengthened through the development of the DXS system which will work as an integral part of practice clinical IT systems, providing a directory of services and detailed information on agreed care pathways and local referral criteria.

5. Our Strategic Approach

The previous sections have highlighted that there is a real opportunity to build upon the high standards of provision in Berkshire West to create an expanded primary care sector as described in our Strategic Plan, but also a risk that this may be stifled by the pressures currently facing general practice. This strategy therefore takes a maturation approach whereby we will first look to support primary care providers to address the very real challenges they are facing, moving on to develop the new models of care described above, with a view to the primary care sector as a whole then being in a position to take a lead role in delivering the innovation required to create the integrated health and social care system we envisage operating in Berkshire West by 2019. The workstreams and investment plan set out below span these three areas and will inform the development of a more detailed Implementation Plan.



a) Workstreams to deliver our Strategic Objectives

Strategic objective for primary care	Anticipated workstreams
1: Addressing current pressures and creating a sustainable primary care sector.	• Supporting new roles in primary care, e.g. Physicians' Associates, prescribing pharmacists, AHPs. • Development of generic primary care nurse role allowing greater flexibility around where care can be delivered. • Expansion of training provision and development of network of multi-professional training practices. • Offering student nurse placements in primary care • Shared training programmes for existing staff including clearer career structures for e.g. practice nurses and administrative staff. Greater sharing of training with other providers / across disciplines. • Development of new roles around care planning and signposting e.g. care navigators, voluntary sector co-ordinators and enhanced case co-ordinator roles • Supporting collaborative approaches to recruitment and development of shared posts and portfolio careers. • Shared locum arrangements. • More effective linking with HETV and other appropriate organisations around workforce planning and training provision. • More co-ordinated appraisal system and CPD arrangements including a structured programme to support nursing revalidation and care certification for HCAs. • Further development of specialist nursing and medical roles working across networks of practices. • Supporting text messaging to communicate messages to patients • Install new servers, single domain and Wi-Fi in every practice. This is the biggest upgrade to GP Practice IT in 20 years and will mean Berkshire West has one of the most advanced infrastructures in the country. • Development of premises strategy, focussing on Reading and Wokingham initially.
2: Interfacing in new ways with specialisms historically provided in secondary care to manage increasingly complex chronic disease in a	• Roll out of existing community-based pathways to other specialties e.g. respiratory medicine. • Development of virtual outpatient clinic model and more community-based clinics • Expansion of community-based consultant roles, building on community geriatrician and community diabetologist models • Improving interface between primary and secondary care clinicians, e.g. greater provision of advice via Choose and Book, E-referral

community setting	and other means, using technology to share information between clinicians electronically, psychiatrists to visit practices to jointly review patients with complex mental health needs. • Further developing GP specialist roles working across clusters of practices, including in mental health in order to support effective management of mental health conditions within primary care. • Supporting the roll out of Eclipse from Diabetes to provide risk stratification system for use across GP Practices in West Berkshire to identify Long Term Condition Patients at risk of emergency admissions.
3: Managing the health of a population in partnership with others. Acting as accountable clinicians for the Over 75s and other high risk patients and co-ordinating an increasingly complex team of people working in primary, community and social care to support patients at home	• Systematic development and implementation of risk profiling and multi-disciplinary care planning for Over 75s and patients with complex health needs, including improved sharing of information and using technology to further develop the role of patient in managing their care. Anticipatory Care CES to be commissioned in 2015-16 supporting face-to-face care planning, medications review and sharing of information through Adastra. Improving care planning and systematic annual reviews for patients with chronic mental health needs and improved processes to review the health needs of patients with a learning disability. GP job plans to include care planning as a core component of their regular workload. • Improving interface between primary care, community services, social care and the voluntary sector through the development of neighbourhood clusters based around groups of GP practices. • Building on existing preventative work e.g. targeted screening for diabetes and exercise schemes to focus more strongly on promoting health and wellbeing amongst the practice population and ensure such work is appropriately reflected in contractual arrangements. • Supporting practices to better meet the needs of carers, including through provision of Directory of Services enabling improved signposting to voluntary sector support. • Supporting information sharing between practice and wider health and social care system through the Berkshire West Connected Care Programme
4: Offering extended provision to improve access and better meet the needs of patients requiring urgent care. Using new approaches to ensure	• Practices to be commissioned to offer more appointments in the evenings/early mornings and on Saturday mornings, and potentially at peak times in-hours. Smaller practices to be encouraged to work collaboratively to increase appointment availability, sharing patient records as appropriate. Extended hours sessions to include routine and urgent appointment capacity. • Empowering patients to self-care where possible and to access services appropriately.

access to primary care in line with patient need.	• Enabling practices to utilise technology to maximum effect to offer patients different options for accessing services e.g. via telephone or online consultations or through email advice portals. • Supporting practices to work together to respond to same-day demand in new ways thereby meeting urgent needs more efficiently and freeing up capacity for other aspects of primary care. To include considering shared call handling / urgent clinic models and potential role of NHS 111 in triaging in-hours calls. • Further exploration of potential role of community pharmacy as part of urgent care response. • Establishing clearer standards and expectations of practices with regard to capacity based on review of current local practice and patient feedback. • Supporting practices to deliver care through mobile working of existing practice system • Ensuring availability of a same day primary care response to patients in mental health crisis as part of the implementation of the local action plan linked to the Mental Health Crisis Care Concordat.
5: Making effective referrals to other services when patients will most benefit	• Roll-out of the DXS system and the associated service directory to be available to all practices and to include information on voluntary sector provision and carer support. • QIPP scheme to reduce variation in referrals and non-elective admissions where there is no clinical rationale behind this. To be delivered through peer review, CCG support and education sessions.

b) Co-commissioning

Delivery of our strategy will be underpinned by recently agreed co-commissioning arrangements with NHS England. The CCGs have been approved to jointly commission primary medical services with NHS England with effect from 1st May 2015. Responsibilities will be discharged through the Joint Primary Care Co-Commissioning Committee and will reflect the nationally determined scope of joint commissioning arrangements as well as guidance around governance and arrangements for managing conflicts of interest. Over time consideration will be given to moving to a fully delegated model.

Co-commissioning will play a crucial role in the delivery of the workstreams outlined above. It will enable CCGs to influence the content and management of core and enhanced primary care contracts (within national parameters) and to align the commissioning of primary care with the organisations' broader commissioning intentions, thereby enabling care to be commissioned across the full extent of the patient pathway.

The following opportunities and priorities have been identified:

- Through co-commissioning we will work to further develop our local definition of what high quality primary care looks like, what level of service patients can expect and anticipated outcomes, linking back to the strategic objectives set out in this document. We will take every opportunity to reflect this in contractual arrangements and in decision-making with regard to future practice changes. This will include encouraging 'upscaling' and collaboration between practices as we have recognised that this will best support delivery of the models of care described in this Strategy. We will work to develop an APMS contract offer as well as a similar consolidated 'contract plus' offer for GMS and PMS practices (following conclusion of the forthcoming NHSE review of PMS contracts) which reflect our strategic objectives and will reduce the bureaucracy associated with managing multiple contracts. This will move us towards our vision of ensuring that all patients have access to a defined level of service irrespective of the model of delivery.

- Linked to this, the CCGs will work with NHS England to develop a framework for further improving quality and addressing unwarranted variation in primary care. This will incorporate CCG-led peer support and sharing of best practice alongside arrangements to address any ongoing performance issues including those highlighted by CQC inspections. We will explore the potential to develop a local quality incentive scheme (potentially superseding some or all of QOF), aligned to the strategic objectives set out in this document. By risk mapping practices on an ongoing basis we will also be able to ensure that we offer targeted support to practices experiencing particular issues and work with those most under pressure to develop plans for the future.

- Through co-commissioning we will work to ensure that any PMS premium funding released as a result of the review of PMS contracts is re-invested in such a way as to further our strategic objectives for primary care. Over time the CCGs will look towards aligning funding levels for all practices irrespective of the type of contract they hold.

- We will work to develop a strategic plan for primary care premises, ensuring that investment is targeted towards premises developments which will underpin delivery of the new models of primary care described in this strategy and that the system is able to respond proactively when national funding streams are made available

c) CCG-level planning

The four GP Councils have been engaged in the development of this strategy through a series of workshops and the strategic objectives set out in this document reflect the collective output of these sessions. However whilst the associated workstreams (see above) will span the four CCGs, it is envisaged that implementation arrangements will vary between them, reflecting their differing population needs and the nature of their existing models of primary care provision. The focus of developments to date within the CCGs has also varied somewhat and further Council discussion will be required as set out in Section 7, in particular to consider any aspects of the strategic objectives for primary care for which a local approach has not yet been agreed.

The following table summarises the extent to which the emerging local vision of each CCG aligns with the broader strategic objectives for primary care identified in this document by identifying key elements of discussion in each area. More detailed information about CCG discussions to date is included in Appendix 2.

	Newbury & District	North and West Reading	South Reading	Wokingham
1: Addressing current pressures and creating a sustainable primary care sector.	• Self-care and automating QOF • New 'GP Personal Assistant' admin role • Freeing up GP time to focus on most complex patients • Multidisciplinary training environment	• Discussions have focussed on how can work together to make roles more attractive. • Consider role of other professionals e.g. pharmacists • Shared approach to multi-disciplinary training, appraisal and CPD	• Discussions have focussed on potential for practices to work more closely together through hub and spoke model thereby creating efficiencies.	• Discussions have focussed on cluster model. This would enable practices to work together to create back office and other efficiencies. • Consider role of Cluster Primary Care Urgent Care Centres
2: Interfacing in new ways with specialisms historically provided in secondary care to manage increasingly complex chronic disease in a	• Direct access diagnostics and new ways of working with consultants	• Building on diabetes model to develop further care pathways and work differently with consultants, including with psychiatrists	• Hubs would have critical mass to offer new services and interface with consultants and others in new ways.	• Clusters would have critical mass to offer new services and interface with consultant and others in new ways.

community setting				
3: Managing the health of a population in partnership with others. Acting as accountable clinicians for the Over 75s and other high risk patients and co-ordinating an increasingly complex team of people working in primary, community and social care to support patients at home	• Continuity when it matters – team of staff focussing on most needy patients; linking with other services as appropriate	• Looking to establish care planning for all long-term conditions • Preventative work e.g. Beat the Street • Age UK care workers • Practices to work as part of integrated Neighbourhood Health and Social Care Teams	• Hubs would act as point of interface with other organisations, thereby supporting cluster working as set out in BCF plan. • Practices could collaborate to meet on the day demand thereby freeing up time for care planning for patients with the highest needs.	• Cluster Care planning working with Care Navigators • Social workers, housing officers etc would be aligned to clusters enabling services to work together more effectively to meet people's needs in the community. • Voluntary Sector Co-ordinator role to be piloted.
4: Offering extended provision to improve access and better meet the needs of patients requiring urgent care. Using new approaches to ensure access to primary care in line with patient need.	• Exploring shared call handling and collaborative approach to 'extras'	• Additional extended hours capacity to be commissioned in accordance with patient need – evenings and Saturday mornings	• Hub and spoke model would offer flexible approaches to extended hours provision and potentially in-hours requests for same day appointments.	• West cluster to pilot collaborative approach to meeting demands for urgent care and providing extended hours.
5: Making effective referrals to other services when patients will most benefit	• Directory of Services likely to be delivered as part of DXS system. To facilitate direct access to other professionals and improved service navigation.			• DXS information will improve co-ordination of care and links with voluntary sector. • Considering how to reduce variation in referral rates for some time and now working with other CCGs on BW scheme.

6. Investment plan

Core primary care services are funded through NHS England's GP commissioning budgets. A high-level summary of 2014-15 budgets is provided below. Further enhanced services are commissioned by unitary authority Public Health departments.

CCG	GP Contract Payment £000	QOF and Aspiration £000	PCO Admin £000	GP Drugs Payments £000	GP Premises £000	Misc. Items £000	Enhanced Services £000s	Total Area Team £000
Newbury and District	8,464	1,197	331	515	1,197	125	812	12,641
North and West Reading	8,892	1,139	312	427	1,127	117	762	12,776
South Reading	12,245	1,056	380	490	1,777	143	917	17,007
Wokingham	10,980	1,625	449	608	1,786	169	1,102	16,720
Total	**40,580**	**5,017**	**1,472**	**2,040**	**5,887**	**554**	**3,592**	**59,143**

CCG budgets relating to primary care in 2015-16 are set out below. In addition to GPIT funding of £1.3m and established enhanced services funding of £0.5m, we intend to use the £5 per head funding to support the care of the Over 75s (as per the 2014-15 planning guidance) to invest in an Anticipatory Care CES designed to significantly advance our third Strategic Objective (Managing the health of a population in partnership with others). In addition, the Better Care Fund plans we have agreed with the local unitary authorities include £2.5m of this pooled budget being invested in extending GP access into extended hours and at peak times in-hours, following a £1m pilot scheme in 2014-15. These two schemes equate an 8.4% increase in investment in primary care. Details of current IT investment plans are included in Appendix 3, below.

	CCG Budgets				
CCG	£5 per head "anticipatory care" £000	BCF Enhanced Access £000	Enhanced Services Recurrent £000	GPIT £000	Total CCG £000
Newbury and District	576	576	101	299	1,552
North and West Reading	560	560	116	279	1,515
South Reading	643	643	94	352	1,732
Wokingham	722	722	187	406	2,037
Total	**2,500**	**2,500**	**498**	**1,336**	**6,836**

Further investment in primary care may follow where it is identified that this will result in overall cost savings in other parts of the CCGs' commissioning budgets. It is also intended however that the strategy will be delivered through the re-alignment of existing commissioning budgets to better reflect the strategic objectives described. As set out in the above co-commissioning section, key priorities will include:

- Development of an APMS offer that reflects our strategic objectives with KPIs aligned to local patient need.
- Redesign of QOF to reflect local priorities.
- Ensuring infrastructure investment furthers our strategic aims.
- Re-investment of released PMS premium funding in service models which reflect this strategy, and with the intention of aligning GMS and PMS funding levels in the future. The mechanisms for doing this require further discussion.

7. Delivering the Strategy

The following table summarises the outcomes that would result from successful delivery of our strategic objectives. Baselines and mechanisms for reviewing progress against these outcomes will be agreed by the Joint Primary Care Co-Commissioning Committee which will assess progress and review the strategy periodically in the light of developments in co-commissioning and in the broader health and social care economy's approach to integration and sustainability.

Strategic objectives	Outcome measures
1: Addressing current pressures and creating a sustainable primary care sector.	• Decreased number of vacancies within practices, application rates improved as primary care is seen as a more attractive place to work. • Staff satisfaction improved • Smaller practices working in federation or other collaborative forms from fewer/better premises serving populations of at least 6,000 but ideally 10,000 patients • No new contracts awarded to single-handed practitioners or practices that would have a list size of less than 6,000 • All primary care premises are fit-for-purpose • Primary care workforce diversified to include pharmacy, nursing, therapists and physicians associates. • Multidisciplinary and joined up arrangements in place for pre-registration training and continuing professional development • Practices receive a consistent level of funding for a defined level of service so that patients in Berkshire West have access to a consistent level of provision. • Services provided outside of core contracts are resourced appropriately. • Contractual arrangements simplified and bureaucracy reduced. • Quality standards are maintained or improved and unexplained variation between practices is addressed. • Strategy underpinned by a robust financial plan which incentivises new ways of working.

2: Interfacing in new ways with specialisms historically provided in secondary care to manage increasingly complex chronic disease in a community setting	• New care pathways in place between primary and secondary care resulting in fewer visits to hospital. • Improved control of long-term conditions e.g. reduced HbA1C level etc • Positive feedback from patients with long-term conditions
3: Managing the health of a population in partnership with others. Acting as accountable clinicians for the Over 75s and other high risk patients and co-ordinating an increasingly complex team of people working in primary, community and social care to support patients at home	• Directory of Services in place supporting improved links with the voluntary sector and increased signposting to voluntary services. • Risk stratification actively used to identify and develop care plans for at-risk individuals. • Preventative work in place with lower risk groups. • Improved patient feedback regarding co-ordination of care • Interoperability achieved and services therefore able to share information with patient consent
4: Offering extended provision to improve access and better meet the needs of patients requiring urgent care. Using new approaches to ensure access to primary care in line with patient need.	• Primary care available from 8am-8pm in the week and on Saturday mornings. • Improved patient survey results / Friends and Family test responses
5: Making effective referrals to other services when patients will most benefit	• Unwarranted variation in referral and non-elective admission rates reduced for specialties where this has been identified.

8. Next steps

Section 5 of this document describes the progress of the individual CCGs in formulating a local vision for primary care which will support delivery of the four overarching strategic objectives for primary care. As part of signing off this strategy, the four GP Councils will be asked to further review the extent to which the vision they have articulated to date, together with the associated local workstreams, will deliver the strategic objectives for primary care set out here, and to consider developing a 'Plan on a Page' around the key aspects of this Strategy. The resulting plans will be discussed at a joint meeting of the four GP Councils. As well as providing an opportunity for Councils to share ideas, this will aim to ensure that co-ordination between local projects and the overarching workstreams and enable identification of any areas of overlaps or potential for gaps in delivery.

Further engagement with patients around the workstreams set out in this Strategy will be undertaken as part of the CCGs' broader Communications and Engagement Strategy. An associated primary care communications plan will be developed.

Delivery of the strategy will be overseen by the Joint Primary Care Co-Commissioning Committee. The Committee will develop an implementation plan which will form the basis of a strategic programme for primary care for which it will take lead responsibility, identifying and working to mitigate risks as appropriate. It will also link extensively with the CCGs' other Programme Boards around specific workstreams.

Appendices

Appendix 1: Summary of key messages from patient engagement to date

The following table has been collated based on feedback from Call to Action events in 2014, the Reading GP question time event held in November 2014, a patient engagement event focussing on primary care held in Newbury in March 2015 and Wokingham CCG engagement around cluster working, as well as discussion with individual Patient Voice Groups.

As set out above, a more detailed Communications and Engagement Plan will be developed around the key workstreams identified in this strategy.

Key themes identified through patient engagement to date	How these are reflected in Strategy
People want better co-ordination of care between organisations so that they only have to tell their story once. There is a view that this should be achieved through shared IT system, and should include working to avoid admissions from care homes. Patients with the most complex needs should be prioritised and plans should be in place to ensure they do not have to explain their illness at every consultation. IT systems should ensure confidentiality of data. Technological solutions should not be a substitute for good face-to-face care.	• Integration with social care and other services through neighbourhood clusters will improve communication between organisations • Patients identified as being most at risk of admission will have care plans in place which can be accessed by other organisations through Adastra. This will incorporate specific care planning processes for care home residents. • Berkshire West Connected Care Programme currently allows the out-of-hours GP service to access patients' records with their consent. Over time this will be expanded to cover A&E and other organisations. Data confidentiality and information governance are key considerations in all initiatives being progressed under this programme. The programme aims to ensure that technology is used to maximum effect to support patient consultations and enhance patients' overall experience of care.

Whilst satisfaction with opening hours is generally high, a significant proportion of patients would like their GP practice to be open more in the evenings and at weekends, although others felt that good access in-hours with an ability to see their own GP was as important as extended opening. Appointments could also be different lengths according to patient need.	• We will commission practices to provide extended hours opening across weekday evenings and on Saturday mornings, in some cases working together to maximise access for patients. Maintaining and expanding capacity in-hours, particularly at peak times, will also be a focus. • Under the 2015-15 GP contract, practices are required to offer patients a named GP responsible for co-ordinating their care.
People recognise that there is a need to promote self-care and to ensure that patients access services appropriately.	• We will use new technology to support self-care as a component of care for patients with long-term conditions. • Our Communications plan will provide more information about self care for minor ailments and appropriate usage of A&E and other services.
People believe that the voluntary sector could play a greater role in meeting peoples' needs, although there it is important to assure the quality of the services offered and to fund these organisations appropriately. GPs need to be more aware of voluntary sector provision.	• Wokingham CCG are piloting a Voluntary Sector Co-ordinator role as part of their cluster working project. • We are working to improve signposting to voluntary sector provision for example through the Directory of Services linked to the new DXS system and through pilot role such as the Voluntary Sector Co-ordinator in Wokingham. The provision of information about support to carers through this system is also being explored.
People identified the need for primary care to work with other agencies to support wellbeing and help prevent mental health issues. A particular focus should be ensuring that young families have access to the support they need. Young people were also identified as a priority group.	• Our vision for primary care involves practices working at the heart of the communities they serve and with other agencies to prevent both physical and mental ill health and to work as proactively as possible to minimise the impact of illness. • Wokingham's pilot Voluntary Sector Co-ordinator role will have a particular focus on the needs of young families moving to the area. • Information on support services and organisations will be better available to

	practices through the DXS system (see above).
There is also a view that GP practices should routinely offer more information on the benefits of exercise and how to prevent diabetes and that young families need more support. It was recognised that practices should work in partnership with other organisations to enable early intervention and prevention of more complex health issues.	• NWR and Wokingham GPs are promoting physical exercise through the 'Beat the Street' initiative. We have also commissioned practices to provide support to patients identified as being at risk of diabetes or in the early stages of diabetes. Through this Strategy we will work with Public Health to further build the role of primary care in preventing ill health (see above).
It is recognised that practices will increasingly involve teams of different healthcare professionals, thereby widening the workforce.	• The workforce sections of this Strategy describe how different professionals such as Physicians' Associates, pharmacists and emergency care practitioners. may increasingly become involved in delivery primary care, with a wider practice team working to support the specific needs of different groups of patients.
People want more planned care for long-term conditions, including continuity of care where possible.	• The CCGs recognise that continuity of care is important to patients with complex needs and where this improves outcomes practices should endeavour to provide this. Where different professionals are involved in a patient's care, care planning and better sharing of information will improve communication between them (see above). GPs are also now required under their contracts to identify a named GP for all patients.

Appendix 2: Summary of CCG discussions to date

Newbury and District CCG	
Strategic Objective 1: Addressing current pressures and creating a sustainable primary care sector	• Services will work to support patients to self-manage their condition where appropriate thereby freeing up GP and other healthcare professionals' time to focus on work that can only be done by them personally. Technological solutions will be employed where possible to enable patients to enter their own data into the GP record where possible, to remind patients to attend for monitoring appointments and to automatically update associated parts of patient records following completion of other elements. • Focussing on patients with the most complex needs (see below) and using skill-mix more effectively will require GPs to work 'at the top of their licence', thereby removing tasks that do not require their input. Whilst the implications of GPs having a more complex casemix will need to be considered, managed appropriately this is likely to make roles in general practice more challenging and rewarding. Extending the role of training and trainee workforce will help foster a learning environment for everyone in the team to benefit from shared expertise and keeping up to date in professional practice. Collaborative approaches to recruiting to posts working in different parts of the primary care system will also be considered.
Strategic Objective 2: Interfacing in new ways with specialisms historically provided in secondary care to manage increasingly complex chronic disease in a community setting	• Direct access diagnostics and improved communications between GPs and consultants will reduce the need for referrals to secondary care and, where these are required, outpatient consultations will increasingly be provided in a community setting by community-based consultants with all appropriate tests having been done in advance. Within Newbury there is also an aspiration to develop a Diagnostic and Treatment Centre which would undertake tests and provide treatment where possible thereby avoiding the need for many patients to be admitted to an acute hospital.

Strategic Objective 3: Managing the health of a population in partnership with others. Acting as accountable clinicians for the Over 75s and other high risk patients and co-ordinating an increasingly complex team of people working in primary, community and social care to support patients at home	• Discussions in Newbury have focussed on the concept of continuity when it matters. This would involve developing GP-lead teams of healthcare professionals able to prioritise a smaller list of patients for whom continuity is important and may affect clinical outcomes (e.g. those with complex multimorbidity, severe enduring mental illness, a severe single condition, or requiring end-of-life care). These teams would consist of GPs, Primary Care Nurses (a new role combining elements of current community and practice nurses), Community Matrons and Physicians Associates, supported by an enhanced 'GP Personal Assistant' administrative role created by freeing up the staff time associated with dealing with on-the-day demand (see below). These staff would mainly be involved with this prioritised list and so would get to know the patients over time.
Strategic Objective 4: Offering extended provision to improve access and better meet the needs of patients requiring urgent care. Ensuring appropriate access to primary care services in line with patient need.	• The Newbury practices are exploring the potential of shared call handling provided either through one or more central hubs, or by using a locally-agreed uniform protocol to handle in-hours requests for GP appointments. This will create efficiencies within practices allowing administrative staff to take on enhanced roles (see below). Using a standard threshold for appointments could then enable practices to work collaboratively to meet excess on-the-day demand through a hub involving GPs, minor illness nurses and Nurse Practitioners. This will free up the time of GPs and others to focus on the patients who most need their care and will give GPs more control over their working day, thereby potentially improving retention. Hub working will also support more effective links with social care and other services. • Electronic consultations will enable GPs to review a succinct patient history prior to seeing or speaking to the patient. It is likely that telephone and/or Skype consultations will also become more common.
Strategic Objective 5: Using the DXS system to make effective referrals to other services when patients will most benefit	• Newbury GPs have discussed the concept of a Directory of Services which is likely to be delivered as part of the DxS system (see above). This will be used by practices, NHS 111 and out-of-hours to facilitate direct access to other appropriate professionals e.g. IAPT, Social Services, Physiotherapy etc. A service navigation function will support patients and practices to access the services they need.

North and West Reading CCG	
Strategic Objective 1: Addressing current pressures and creating a sustainable primary care sector	• Practices in the CCG recognise the need to make General Practice in North and West Reading an attractive place to work and will work together on this in order to respond to the current workforce crisis. As well as considering how posts can be made more attractive, the role of other professionals such as pharmacists will be further developed. Improving retention of staff will be a particular focus and it is felt that a more co-ordinated and multi-disciplinary approach to training, appraisal and continuing professional development focussed on the particular needs of the local population will support this.
Strategic Objective 2: Interfacing in new ways with specialisms historically provided in secondary care to manage increasingly complex chronic disease in a community setting	• Practices in the CCG are keen to build upon the success of the diabetes model to develop further community-based pathways with a strong self-care component for patients with other long-term conditions. Improved access to consultant advice should work to reduce referrals and support the management of patients within primary care. One of the strong features of the diabetes model is that GPs regularly meet with the Consultant Diabetologist and have direct access to him for urgent advice. The CCGs hopes to expand this to have better access to all other Consultants. GPs also want to ensure that there is a process for direct "doctor to doctor" conversations about any concerns about the quality of care delivered to patients in the hospital and community. The CCG wishes to see patient centred care /care planning adopted for all long-term conditions. This is at the centre of the Diabetes re-design and the respiratory work that is happening in 2015/16. • The interface with mental health services is a particular area of focus and GPs wish to improve the availability of advice from consultant psychiatrists and other mental health professionals.
Strategic Objective 3: Managing the health of a population in partnership with others. Acting as accountable clinicians for the Over 75s and other high risk patients and co-ordinating an increasingly complex team of people working in primary,	• The CCG will work with practices to take a more preventative approach to care. A key focus will be on promoting walking and cycling through an extended 'Beat the Street' campaign. Work is also underway to support the national cancer screening programmes and to identify and address gaps in the support provided to carers in primary care. The CCG will maximise opportunities to better support our population with self-care. • Providing better co-ordinated and proactive care for frail elderly patients is a key priority for all practices in the CCG.

community and social care to support patients at home	The CCG will work with and further develop the community geriatrician model to support practices avoid unnecessary admissions. As well as embedding and further developing care planning for those with the most complex needs, the CCG plans to commission two Age UK care workers to proactively seek out and support older people, particularly those socially isolated, not currently under medical or nursing care. Over time practices will look to work as part of Integrated Neighbourhood Health and Social Care Teams providing more joined up care for patients.
Strategic Objective 4: Offering extended provision to improve access and better meet the needs of patients requiring urgent care. Ensuring appropriate access to primary care services in line with patient need.	• The CCG will look to commission further extended hours working in a way that addresses patient need and maintains GP work/life balance without de-stabilising core in-hours and out-of-hours provision. In common with the broader principles set out elsewhere in this Strategy, at present this is likely to involve practices offering additional capacity in the evenings and on Saturday mornings, working collaboratively to do this where appropriate.
Strategic Objective 5: Using the DXS system to make effective referrals to other services when patients will most benefit	• To be considered further by the NWR GP Council.

South Reading CCG

In South Reading primary care discussions to date have focussed on how GP practices might work together to address the challenges of growing demand and difficulties in recruitment and to expand the primary care sector. South Reading practices are well-placed to offer services collaboratively as there are a large number of smaller practices working in close geographical proximity. A sub-group of the Council is currently meeting to explore how the CCG can move towards a network of geographically-determined 'hubs and spokes'.

Strategic Objective 1: Addressing current pressures and creating a sustainable primary care sector	• The hub and spoke model would offer significant potential efficiencies for practices in terms of sharing back office functions, providing enhanced services collaboratively and offering opportunities to work together to address growing demand.
Strategic Objective 2: Interfacing in new ways with specialisms historically provided in secondary care to manage increasingly complex chronic disease in a community setting	• Hubs would potentially serve a population of around 25,000 and would therefore have the critical mass required to offer services beyond those historically provided in general practice and to interface with consultants and others to provide more community-based care. Practices would also be able to collaborate to provide enhanced services.
Strategic Objective 3: Managing the health of a population in partnership with others. Acting as accountable clinicians for the Over 75s and other high risk patients and co-ordinating an increasingly complex team of people working in primary, community and social care to support patients at home	• Hubs would act as a point of interface with other organisations, thereby supporting the development of cluster working as described in Reading's Better Care Fund Plan. • Practices would also be able to work collaboratively through hubs to offer enhanced services and potentially also to meet on-the-day demand for services, freeing up time within 'spoke' practices to proactively plan care for patients with the highest level of need.

Strategic Objective 4: Offering extended provision to improve access and better meet the needs of patients requiring urgent care. Ensuring appropriate access to primary care services in line with patient need.	• Practices would collaborate through the hub model to meet the needs of patients requiring same day appointments and to offer extended hours provision.
Strategic Objective 5: Using the DXS system to make effective referrals to other services when patients will most benefit	• To be considered further by the South Reading GP Council.

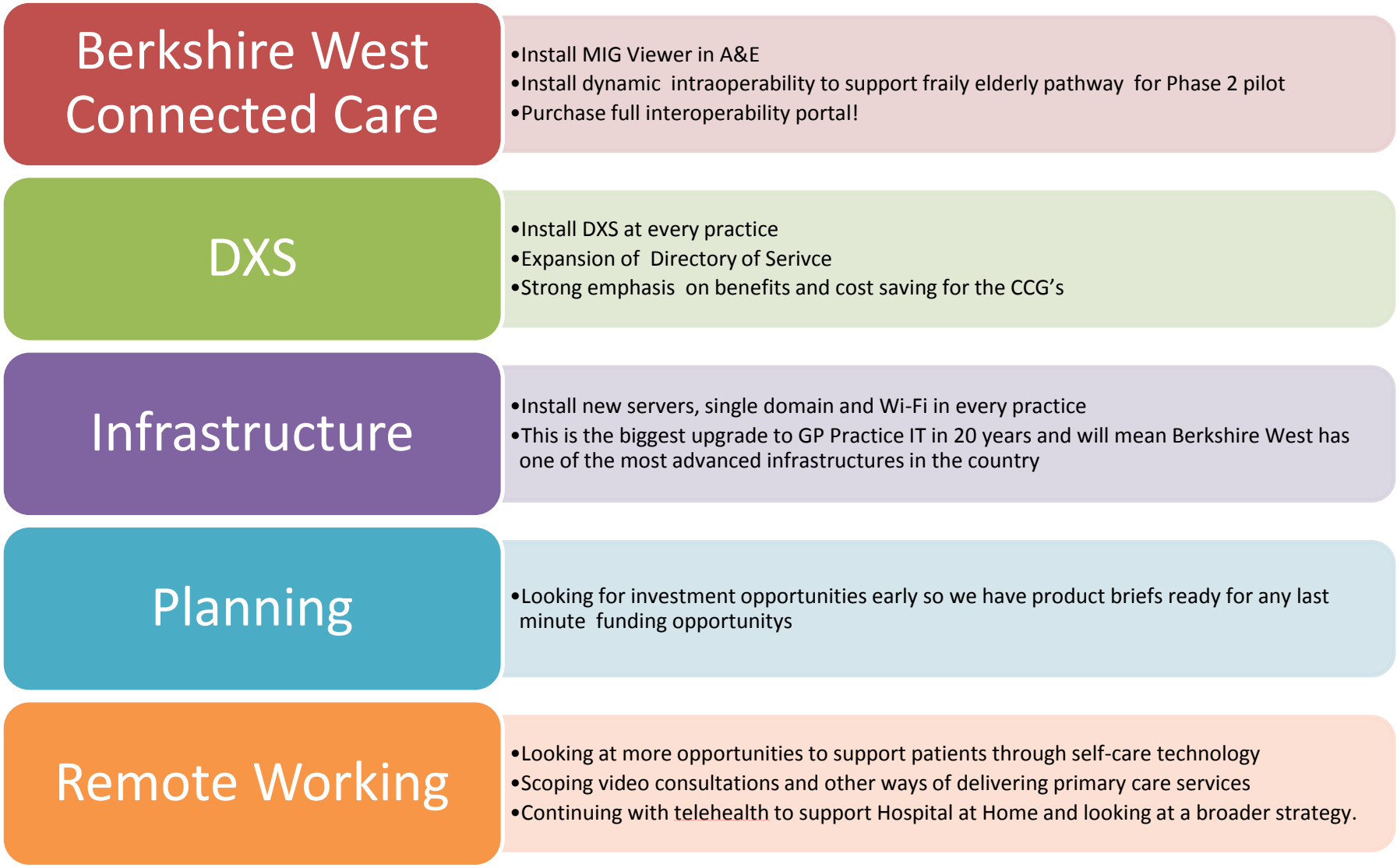
Wokingham CCG

Wokingham CCG is working with Wokingham Borough Council and other partners on the development of cluster working. Clusters will be a grouping of services working together to meet the needs of a defined population. There will be three clusters within Wokingham (East, West and North), each serving a population of 40 – 60,000 people. Wokingham is experiencing significant population growth as a result of new housing development and key focus is planning to meet the primary care needs of an estimated additional 32,000 residents by 2022. Each cluster will pilot a key collaborative project in the first year which will be evaluated and rolled out as appropriate. Cluster working will enable practices to work together to address key challenges such as recruitment and retention and growing demand, thereby delivering a more sustainable workload for primary care teams.

Strategic Objective 1: Addressing current pressures and creating a sustainable primary care sector	• Cluster working offers significant opportunities for practices to work more efficiently by sharing back-office functions, working together to meet rising demand and potentially providing services collaboratively.
Strategic Objective 2: Interfacing in new ways with specialisms historically provided in secondary care to manage increasingly complex chronic disease in a community setting	• Clusters will have the critical mass required to offer services beyond those historically provided in general practice and to interface with consultants and others to provide more community-based care. There will be opportunities to further develop GP specialists supporting a number of practices and to work in new ways with secondary care clinicians.
Strategic Objective 3: Managing the health of a population in partnership with others. Acting as accountable clinicians for the Over 75s and other high risk patients and co-ordinating an increasingly complex team of people working in primary, community and social care to support patients at home	• Over time, by managing urgent demand collaboratively, clustering should free up GP time to focus their efforts on providing proactive, community-based care for patients with higher levels of need. • It is envisaged that social workers, housing officers and other key professionals in other services will be aligned to clusters thereby enabling services to work together jointly to plan for meeting patients' needs in the community. • The Clusters will bring in the role of care navigators. This will support practices to signpost people to the extensive range of voluntary sector services available to them. It will also work to reduce social isolation amongst older people and will work proactively to help people to access support at an early stage. A further focus will be meeting the needs of young families moving into the Wokingham area who may not have local family networks to support them.

Strategic Objective 4: Offering extended provision to improve access and better meet the needs of patients requiring urgent care. Ensuring appropriate access to primary care services in line with patient need.	• The Clusters will pilot a joint approach to meeting demands for urgent care through a cluster based primary care urgent care centres with a particular focus on working together to deliver both in hours and extended hours services. Opportunities to work jointly to respond to requests for same day appointments will also be explored.
Strategic Objective 5: Using the DXS system to make effective referrals to other services when patients will most benefit	• Co-ordination of care between services and links with the voluntary sector will be underpinned by information provided through DXS which will be readily available to all practices. • Wokingham CCG has been considering how to reduce variation in referral rates between practices for some time and will work with the other CCGs on the implementation of a Berkshire West scheme to progress this.

Appendix 3: IM&T investment plans



REPORT FROM SOUTH READING CLINICAL COMMISSIONING GROUP (SRCCG) & NORTH & WEST READING CLINICAL COMMISSIONING GROUP (NWRCCG)

TO:	**HEALTH AND WELLBEING BOARD**		
DATE:	**17th July 2014**	**AGENDA ITEM:**	**7**
TITLE:	**SOUTH READING & NORTH & WEST READING QUALITY PREMIUM TARGETS 2015/16**		
LEADS:	**DR ISHAK NADEEM**	**TEL:**	**0118 921 3827**
	DR ANDY CIECIERSKI		**0118 982 2917**
JOB TITLE:	**CHAIR, SOUTH READING CCG**	**E-MAIL:**	**ishak.nadeem@nhs.net**
	CHAIR, NORTH & WEST CCG		**aciecierski@nhs.net**

1. PURPOSE OF REPORT AND EXECUTIVE SUMMARY

Under the National Health Service Act 2006 (as amended by the Health and Social Act 2012), NHS England has the power to make payments to Clinical Commissioning Groups (CCGs) to reflect the quality of services that they commission, the associated health outcomes and reductions in inequalities. NHS England has produced "Quality Premium Guidance" for CCGs for 2015/16. The Quality Premium is intended to reward clinical commissioning groups (CCGs) for improvements in the quality of the services that they commission and for associated improvements in health outcomes and reducing inequalities.

The Quality Premium measures agreed in 2015/16 will be paid to CCGs in 2016/17 – to reflect the quality of the health services commissioned by them in 2015/16 – and will be based on **six** measures that cover a combination of national and one local priority. Some of these measures are required to be signed off by the health and Wellbeing Board. This paper outlines the measures and the targets that have been set by the individual CCGs.

RECOMMENDED ACTION

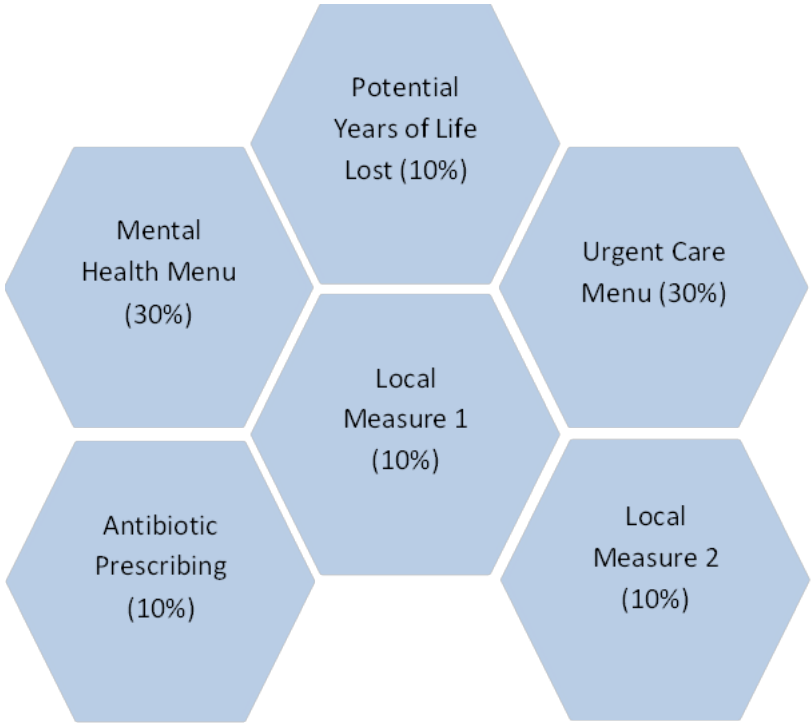
To note and agree the following quality premium measure targets set for North & West Reading CCG and South Reading CCG for 2015/16:

1. **Weekend discharge indicator is picked for the whole 30% of the urgent and emergency care measure (NWRCCG & SRCCG);**
2. **The paid employment indicator is picked for the whole 30% of the mental health measure (NWRCCG & SRCCG);**
3. **Increase referrals to Eat 4 Health (SRCCG);**
4. **Increase referrals to alcohol service IRIS (SRCCG);**
5. **Increase in the number of carers identified by GP practices (NWRCCG);**
6. **Increase in uptake of bowel cancer screening. (NWRCCG).**

2. POLICY CONTEXT

NHS England has produced "Quality Premium Guidance" for CCGs for 2015/16. The Quality Premium is intended to reward Clinical Commissioning Groups (CCGs) for improvements in the quality of the services that they commission and for associated improvements in health outcomes and reducing inequalities.

The Quality Premium measures agreed and achieved in 2015/16 will be paid to CCGs in 2016/17 – to reflect the quality of the health services commissioned by them in 2015/16 – and will be based on six measures (depicted below) that cover a combination of national and local priorities. Some of these measures are required to be signed off by the Health and Wellbeing Board. This paper outlines the measures and the targets that have been set by the individual CCGs that require such sign off.



2.1. Urgent and Emergency Care Quality Premium Indicator

There is a menu of 3 measures for CCGs to choose from locally in conjunction with their relevant Health and Wellbeing Board(s) and local NHS England team. The menu is overall worth 30 per cent of the quality premium. CCGs, with the above partners, can decide whether to select one, several, or all measures from the menu and also what proportions of the 30 per cent are attributed to each measure.

Avoidable Emergency Admissions Composite Measure
The CCGs are all very high performers on non-elective activity where benchmarked against CCGs across the South Central and Nationally. Taking this into account along with the work that is already being done within the Better Care Fund and CCG QIPP schemes to manage non elective activity, it is recommended that this indicator is not selected.

Delayed Transfers of Care with NHS Responsibility

The CCG has reviewed the local provider Trusts and a comparison can be seen below. This shows that the annual numbers are very low as these are based on a snapshot position for the last Thursday of every month. Therefore, if there was one or two really bad last Thursdays, the remainder of the year could be put at risk.

	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Total
RBFT	14	12	21	23	22	22	27	20	14	13	17	205
BHFT	1	0	0	0	2	2	6	4	5	7	7	34
Bucks	22	15	15	11	12	16	15	27	11	18	18	180
OUH	46	65	61	65	74	67	97	77	97	105	87	841

Non-elective admission patients discharged at the weekend or on a bank holiday
The proportion of patients discharged on a Saturday, Sunday or English Public Holiday should be
(a) at least 0.5% points higher in 2015/16 than in 2014/15; OR
(b) Greater than 30% in 2015/16

The current baseline position is below 30%, so the aim will be to achieve a 0.5% increase in 2015/16. This fits with the system resilience plans around patient flow and additional community and social care capacity has been commissioned for weekend discharges. RBFT are also working to increase 7 day working in some key areas within the Trust which would also support achievement of this target.

Recommendation
Therefore, it is recommended that the weekend discharge indicator is picked for the whole 30% of the urgent and emergency care measure.

2.2. Mental Health Quality Premium Indicator

There is a menu of 4 measures for CCGs to choose from locally in conjunction with their relevant Health and Wellbeing Board(s) and local NHS England team. The menu is overall worth 30 per cent of the quality premium. CCGs, with the above partners, can decide whether to select one, several, or all measures from the menu and also what proportions of the 30 per cent are attributed to each measure.

Reduction in the number of patients attending an A&E department for a mental health-related need who wait more than four hours to be treated and discharged, or admitted, together with a defined improvement in the coding of patients attending A&E

a) The proportion of primary diagnosis codes at A&E with a valid 2 character A&E diagnosis or 3 digit ICD-10 code will be at least 90%; AND
b) The proportion of patients with a primary diagnosis of mental health-related needs or poisoning that spend more than 4 hours in A&E is no greater than the average for all patients, or is over 95%

Currently less than 1% of A&E attendances are coded with a valid diagnosis code on SUS. Therefore it will be difficult to achieve the first part of this indicator. This indicator appears to be an annual assessment and therefore there is no time to achieve the increases required in A&E coding to achieve an annual position of 90%.

Number of people with severe mental illness who are currently smokers
After discussion with the Mental Health GP lead there are a number of concerns with this indicator. A large proportion of these patients will no longer be under the care of BHFT and therefore this will depend purely on GP patient reviews. It is known that this is a difficult group

of patients to attend the GP surgery and they will also be a very resistant group to stop smoking. The feedback loop from BHFT to GP practices would need to be improved to ensure that where a patient is referred to the stop smoking service from BHFT and subsequently stops smoking, the GP is informed to ensure the system record reflects this. Therefore it is felt that although this is the right thing to do for patients; this indicator would be particularly difficult to show an improvement against.

Increase in the proportion of adults in contact with secondary mental health services who are in paid employment

a) An increase in the percentage of people in contact with mental Services who are in paid employment.; OR
b) a reduction in the gap between people in contact with mental services who are in paid employment and the employment rate of the general population.

BHFT have a CQUIN in place during 2015/16 which requires an increase in the number of community mental patients who are in purposeful activity, defined as education, training employment or volunteering. This will therefore support the CCG if this is chosen as the quality premium indicator. NHSE has confirmed that we do not need to specify the increase and any increase would be classed as achievement.

Improvement in the health related quality of life for people with a long term mental health condition

This indicator would require a reduction in the difference between the health related quality of life for people with any long term conditions compared to those with a mental health long term condition. The data source for this indicator is the GP survey. It is very difficult to directly make an improvement on the survey as we could make a difference for a cohort of patients who then they may not get asked to complete the survey. We've had real problems with year on year variation on the scores for different questions in this survey which could just be natural variation due to the different patients completing the questionnaire. We also normally benchmark well on the survey, making it even harder to improve. Following discussions with the GP Mental Health Lead, it is recommended that this indicator is not selected.

<u>Recommendation</u>

Therefore, it is recommended that the paid employment indicator is picked for the whole 30% of the mental health measure.

3. Local Quality Premium Indicators (South Reading CCG)

As part of NHS England guidance, CCG local targets should be chosen from an area of local concern i.e. they should reflect the local priorities identified in joint health and wellbeing strategies. As part of the exercise to address areas of greatest health need within South Reading CCG, a number of data sets were used to understand where the Quality Premium could be focussed. These have been linked back to the Health and Wellbeing strategy for Reading. The methodology for this decision is described in 3.2 below.

3.1 Our population

The population of South Reading is different to its neighbouring CCGs. It is an inner city area serving University students with different health needs and a younger population profile compared to other parts of the country. Life Expectancy is lower than the England average and

the area has significant pockets of deprivation. Some of our neighbourhoods are in the 20% most deprived areas in the country including Whitley, Church, Norcot and Redlands.

3.2 Review of the data sources

The CCG reviewed the following data sets as part of the review to identify areas of concern: Outcomes Indicator Set, bench marking data compared to CCGs with similar demographics and local intelligence from Programme Boards.
Following a review of these data sources, the areas the CCG is an outlier are as follows:

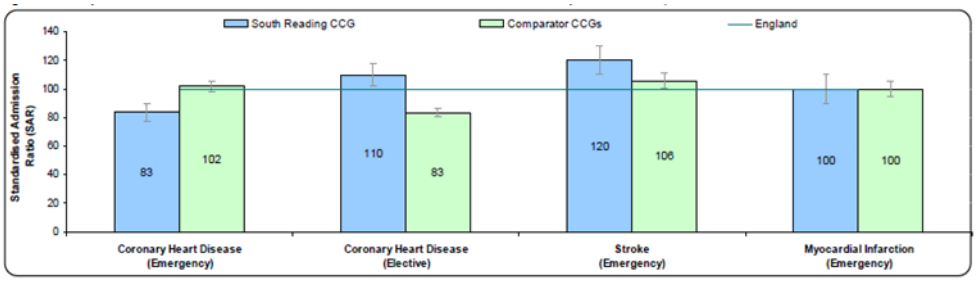
- Ischaemic Heart Disease/Stroke
- Liver Disease
- Obesity

The following data sources show how the CCG benchmarks compared to Local Authority comparator groups and the rest of England:

Circulatory disease
Circulatory Diseases - Under 75 Mortality per 100,000 Population ,

	Reading		
	Under 75 mortality rate per 100,000 population	Compared to LA comparator group	Compared to all England LAs
Heart disease and stroke	91	Worse than average	Worst quartile
Heart disease	51	Worse than average	Worse than average
Stroke	17	Worse than average	Worse than average

The Emergency admission ratio for Coronary Heart Disease was significantly lower than the national benchmark and comparators CCGs. However elective admissions for Coronary Heart Disease and emergency admissions for stroke were significantly higher.



Obesity
The National Child Measurement Programme (NCMP) measures the prevalence of obesity in 4-5 year olds (Reception) and 10-11 year olds (Year 6). Figure 9 shows that South Reading CCG's prevalence is higher than the England average for both age-groups.

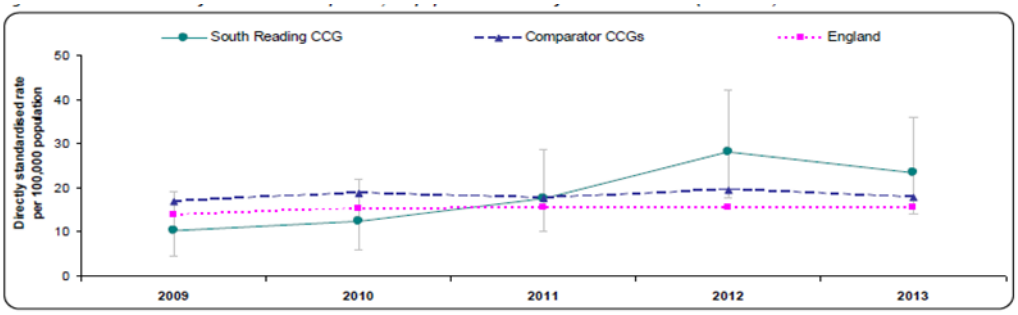
		South Reading CCG Prevalence	England Prevalence
Reception (aged 4 to 5)	*Overweight (including obesity)*	25.4%	22.2%
	Obesity	12.1%	9.3%
Year 6 (aged 10 to 11)	*Overweight (including obesity)*	37.1%	33.3%
	Obesity	21.3%	18.9%

Liver Disease

Under 75 Mortality per 100,000 Population

	Reading		
	Under 75 mortality rate per 100,000 population	Compared to LA comparator group	Compared to all England LAs
Liver disease	25	Worst quartile	Worst quartile

In 2013 21 people aged under 75 died from liver disease. Here you can see the mortality rate over a 5 year period for all people aged under 75.



3.3 Quality Premium target for 2015/16

In summary, in response to areas where we have the greatest need in t South Reading CCG the Quality Premium targets for 2015/16 are recommended as:

Local Measure	CCG target	Impact	Aligns to HWB goal
1. Increase referrals to Eat 4 Health	Increase GP referrals from 139 to 250 by 31 March 2016 (80% increase)	Allows us to tackle Obesity and its related impact on other conditions such as Diabetes and Cardiovascular Disease	Goal Four – Promote health-enabling behaviours & lifestyle tailored to the differing needs of communities Goal Three – Reduce the impact of long term conditions with approaches focused on specific groups
2. Increase referrals to alcohol service IRIS	Increase GP referrals from 25 to 150 by 31 March 2016 (500% increase)	Allows us to support Berkshrie West wide programmes e.g. QIPP schemes to tackle rising problem in our local area	Goal Four – Promote health-enabling behaviours & lifestyle tailored to the differing needs of communities

These proposed targets have been discussed by South Reading CCG Council of Practices at their meetings on 8 April and 13 May and GPs have agreed this approach for 2015/16.

4. Local Quality Premium Indicators (North & West Reading CCG)

As stated in Section 3 above, CCG local quality premium targets should focus on an area identified as a local priority for the CCG. At its meeting in April 2015 the Health and Wellbeing Board was presented with North & West Reading CCG's refreshed priorities for 2015/16. These included working with partners to identify and address gaps in local GP services to support carers and to reduce the potential years of life lost per 1,000 population from neoplasms compared to the CCG comparator group. The CCG's Quality Premium indicators reflect these two focus areas.

4.1 Quality Premium Indicator - to address gaps in local GP services to support carers

In response to the work commissioned by Public Health Reading to identify and address gaps in local GP services to support carers, the CCG plans to increase the number of carers known to GP practices so that more carers benefit from enhanced support from general practice. The Quality Premium target is to increase the number of carers identified by GP practices and included on a register from 1,251 to 2,502 by the end of March 2016; this is a 1% increase in the CCG's population identified as being carers.

This aligns to the Health and Wellbeing strategy by supporting goals one and three as follows:

Goal One – Promote and protect the health of all communities particularly those disadvantaged	Goal Three – Reduce the impact of long term conditions with approaches focused on specific groups
Objective 2 - Ensure effective support is available to vulnerable and BME groups to protect their own health.	Objective 3 - Build on and strengthen the quality and amount of support available to adult and young carers in Reading

4.2 Quality Premium Indicator - to address potential years of life lost from neoplasms

In response to the CCG having the highest rate of potential years of life lost per 1,000 population for neoplasms compared to the CCG comparator group, we will target one of the major programmes that supports a reduction in this variation, increasing uptake of bowel cancer screening. The Quality Premium target will be to increase uptake of bowel cancer screening from 57.95% (March 14) to 62% by the end of March 2016, this is above the national target of 60%.

This aligns to the Health and Wellbeing strategy by supporting goal one as follows:

Goal One – Promote and protect the health of all communities particularly those disadvantaged
Objective 3 - Increase awareness and uptake of Immunisation and Screening programmes

READING BOROUGH COUNCIL

REPORT BY DIRECTOR OF ADULT SOCIAL CARE & HEALTH SERVICES

TO:	**HEALTH AND WELLBEING BOARD**		
DATE:	**17 JULY 2015**	**AGENDA ITEM:**	**8**
TITLE:	**IMPROVING SUPPORT TO THE EX-GURKHA COMMUNITY: ACCESS TO AND EXPERIENCE OF HEALTH AND SOCIAL CARE SERVICES IN READING**		
LEAD COUNCILLOR:	**COUNCILLOR HOSKIN /COUNCILLOR EDEN**	**PORTFOLIO:**	**HEALTH / ADULT SOCIAL CARE**
SERVICE:	**HEALTH / ADULT SOCIAL CARE**	**WARDS:**	**BOROUGH WIDE**
LEAD OFFICER:	**MELANIE O'ROURKE MANDEEP KAUR SIRA**	**TEL:**	**0118 937 4053 / 0118 937 2295**
JOB TITLE:	**INTERIM HEAD OF ADULT SOCIAL CARE, RBC CHIEF EXECUTIVE, HEALTHWATCH READING**	**E-MAIL:**	**Melanie.O'Rourke@reading.gov.uk / Mandeep@healthwatchreading.co.uk**

1. PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1 Healthwatch Reading has gathered feedback from members of the ex-Gurkha Community on how they access health and social care services and then their experience of those services. This report sets out Healthwatch Reading's recommendations to care providers and the providers' responses.

1.2 Most people who took part in this survey reported difficulties in accessing and using services, principally because of speaking / reading little English and not receiving clear guidance on how to obtain interpreter support. The problems are compounded in that the ex-Gurkha community in Reading needs to understand a very different healthcare system from the one they know in Nepal – with no universal access but many more medicines available over the counter and more direct access to secondary care.

1.3 Health and social care providers have started to address the issues raised, and have committed to making further improvements, working in partnership.

2. RECOMMENDED ACTION

2.1 The Health and Wellbeing Board notes the findings of Healthwatch Reading and the responses from health and social care providers as set out in the report ***How the ex-Gurkha community access and experience health and social care services in Reading.***

2.2 The Health and Wellbeing Board directs the Reading integration Programme Manager to develop and monitor a whole system Action Plan based on the report and responses received, this Acton Plan to be monitored through the Reading Integration Board.

3. BACKGROUND

3.1 In 2014, Healthwatch Reading was commissioned by Reading Borough Council, on behalf of a consortium of local authorities in the south-east of England, to explore how the ex-Gurkha community access health and social care services and to disseminate these finding across the consortium.

3.2 Gurkhas are Nepalese soldiers who have a long history of serving with the British Army. Following a high profile campaign, in 2009 the UK Government gave retired Gurkhas the right to settle in the UK. The local authorities which commissioned this project have seen a significant number of ex-Gurkhas move into their areas since this time.

3.3 More than 100 people from the ex-Gurkha community in Reading gave their feedback on various health and social care services for this study, including

- GPs
- Royal Berkshire Hospital
- Urgent care services: walk-in centre, 111, out-of-hours GPs
- Community opticians and NHS dentists
- Mental health services
- Social care services

4. THE EX-GURKHA POPULATION IN READING

4.1 The 2011 Census indicated that Reading had a Nepalese population of 2,725. This includes migrants of working age, many with professional qualifications, and then ex-Gurkhas and their wives. Most of the ex-Gurkha community are aged 60-75 years, and come from rural areas of Nepal. They are often living in the UK without the support of adult children, who may live back in Nepal.

4.2 The ex-Gurkha community in Reading has a high incidence of a number of long term conditions, including diabetes, hypertension, cardiovascular disease and gout. Many ex-Gurkhas also have hearing problems, caused by exposure to the noise from discharging weapons during army service. Alcohol misuse is a common problem in this community. There is also a high rate of uro-

gynaecological problems (such as incontinence) amongst the ex-Gurkha wives who will typically have had many pregnancies.

4.3 Many ex-Gurkha families in Reading are living on low incomes. Some live in crowded, sub-let housing and may not be able to afford heating. Living in poor housing is a known risk factor for poor health e.g. respiratory problems.

4.4 Community leaders report that significant numbers within the ex-Gurkha community are providing unpaid care to others, particularly spouses, who are frail or unwell. However, most of these people are not known / recognised as carers to statutory or other services. Such is the level of reliance on spousal support that frail older widows or widowers may be particularly vulnerable.

5. RECOMMENDATIONS MADE AND RESPONSES RECEIVED

5.1 Recommendation

GP practices in Reading (in partnership with their commissioners), should review how they can sustainably provide interpreters for the ex-Gurkhas and their wives who need assistance explaining their symptoms and needs during consultations.

Response

The Reading Clinical Commissioning Groups have raised with GPs the issues around accessibility and effectiveness of interpreters for this community. GPs were interested to hear about the experiences of the ex-Gurkha community and keen to make improvements.

GPs were reminded about the process for booking an interpreter and using the translation services. GPs were again reminded that trained interpreters should be offered rather than having members of the family acting in a translator role. Practices were asked to check with their reception desk staff to ensure they were clear on the process too.

Three GPs indicated they have a significantly high population of ex-Gurkhas and two suggested that some of their patients might be willing to be trained and act as interpreters to support other members of the community.

5.2 Recommendation

Community dentists and opticians (in partnership with their commissioners), should review how they can sustainably provide interpreters for the ex-Gurkhas and their wives who need assistance explaining their symptoms and needs during consultations.

Response

Reading Borough Council provides the Interpretation and Translation service referred to in the Healthwatch report, which primary healthcare partners can also access. The Council will aim to improve awareness of this service through its partnership working, including the quarterly Adult Social Care partner newsletter, *Care Junction*.

5.3 Recommendation

The Royal Berkshire Hospital, particularly ophthalmology and audiology clinics (in partnership with their commissioners), should review how they can sustainably provide interpreters for ex-Gurkhas and their wives who need assistance explaining their symptoms and needs during consultations.

Response

Royal Berkshire Hospital staff confirmed that interpreters are booked for patients identified as needing language support (by either the GP or by the patient or relative/representative). For first appointments, notification should come from the GP and a flag is then put on the patient's electronic patient records (EPR) to alert any future staff booking future appointments, that an interpreter in that language is needed.

The interpreters used by the Trust request two weeks' notice ideally, but will try and provide face-to-face at shorter notice if available. In addition, all departments have access to telephonic interpreters and there are several three-way handsets around the Trust for specific telephonic interpreting use.

5.4 Recommendation

Reading's two clinical commissioning groups should consider providing ex-Gurkhas and their wives with an information card that they can show health service staff to indicate that they wish to have an interpreter arranged for their appointment.

Response

The Reading Clinical Commissioning Groups recognise the benefits of an information card as proposed and have committed to discussing this with partners via the CCG Patient Engagement Group, of which Healthwatch is a member, and developing an action plan to progress this.

5.5 Recommendation

GP practices in Reading should review the written information they regularly provide to the ex-Gurkha community to identify whether any of this information – such as appointment letters– should be translated into clear and simple Nepalese. Consideration should also be given on providing translated information on making a complaint, and how to change GP practices.

Response

The Clinical Commissioning Groups shared the Healthwatch report and their response with their GP practices so that they became aware of the recommendation to translate letters. This topic was covered in the CCGs' GP newsletter, and the CCGs committed to working NHS England on developing clear communications around interpretation and translation for surgeries. The CCGs also committed to considering with their Patient Engagement Group a standard phrase to be used directing patients how to arrange translations of CCG produced written information.

5.6 Recommendation

The Royal Berkshire Hospital should review the written information they regularly provide to the ex-Gurkha community to identify whether any of this information – such as appointment letters, the hospital map, should be translated into clear and simple Nepalese.

Response

Royal Berkshire Hospital advised that instructions about booking interpreters are available on their Intranet and that there are posters and leaflets for staff explaining when and how to book interpreters. Posters encouraging patients to request an interpreter (in 17 languages, including Nepali) if required are also available throughout the Trust and posters are also displayed informing patients that they can request written information in different languages or formats if required.

5.7 Recommendation

Community dentists and opticians in Reading should review the written information they regularly provide to the ex-Gurkha community to identify whether any of this information – such as appointment letters – should be translated into clear and simple Nepalese.

Response

Reading Borough Council provides the Interpretation and Translation service referred to in the Healthwatch report, which primary healthcare partners can also access. The Council will aim to improve awareness of this service through

its partnership working, including the quarterly Adult Social Care partner newsletter, *Care Junction*.

5.8 Recommendation

Staff from the Royal Berkshire Hospital's ophthalmology and audiology clinics, should consider undertaking outreach work with the ex-Gurkha community to raise awareness of how to access and use their services and to set expectations on issues such as waiting times.

5.9 Recommendation

Staff from community eye test and NHS dental services, should consider undertaking outreach work with the ex-Gurkha community to raise awareness of how to access and use their services and to set expectations on issues such as waiting times and any costs.

Response

This recommendation was noted and picked whilst the research project was still live when an optometrist gave a talk to a Nepalese women's group on eye tests. Health and social care providers recognise the value of outreach to raise awareness of services within communities whose members are currently under-represented in take-up. Past experience indicates that a targeted and co-ordinated approach to such outreach is likely to prove most effective. This is something which the Reading Integration Board would be well placed to oversee.

5.10 Recommendation

Reading Borough Council should raise awareness among the ex-Gurkha community of free support available to carers and also raise awareness among frontline social care staff of potential unmet needs of vulnerable people within this community and how these might be addressed.

Response

One of the most comprehensive information packs the Council's Adult Social Care service produces is the 'Caring in Reading' guide to local services for anyone who is providing unpaid care to a family member, friend or neighbour. This pack was first translated into Nepalese in 2012 to support Nepalese Health Week, and Adult Social Care staff attended this community event to help raise awareness of social care amongst the Nepalese attendees and take questions.

The pack remains available in Nepalese, although recent demand has been more for individual sections than for the pack as a whole.

The Council noted the ongoing challenge of finding the right words to connect with people providing unpaid care, and that 'carer' does not translate easily into all languages because of different cultural norms. However, clearly Healthwatch Reading was able to describe 'carer' to the focus group participants as 13% went on to identify themselves as carers as well as going on to describe other members of their community as carers. The Council felt this illustrated the importance of face to face contact and discussion in providing effective support to navigate care services, and committed to using this feedback to inform its future commissioning of information and advice services.

The Council will also be reviewing its products and distribution channels for social care information in 2015. The intention is to seek feedback from a number of user/public reference groups to inform this review. In the light of Healthwatch's findings, the Council committed to recruiting an ex Ghurka reference group to take part in this review and provide interpreter support for this as required.

5.11 Recommendation

Reading's two clinical commissioning groups to continue to support Health English for Health language classes for Nepalese women, and consider developing these classes to include access to mental health and social care services.

Response

The Clinical Commissioning Groups have previously funded these courses through the Partnership Development Fund (PDF) grant, but no application was received for 2015/16. The Clinical Commissioning Groups have confirmed they welcome bids from the voluntary sector and would be happy to consider a future funding application for this service.

6. CONTRIBUTION TO STRATEGIC AIMS

6.1 Goal One of Reading's Health and Wellbeing Strategy (2013-16) is to:
"Promote and protect the health of all communities particularly those disadvantaged"
and a specific objective within that is to:
"Ensure effective support is available to vulnerable and BME groups to protect their own health."
Developing a whole system Action Plan to progress and monitor the commitments made in response to Healthwatch's findings would support achievement of this objective. It would also support delivery against the

service priority "safeguarding and protecting those that are most vulnerable" as set out on Reading Borough Council's Corporate Plan (2015-18), and the vision outlined in the Berkshire West Strategic plan 2014-2019 and the Reading CCGs operating plans 2014-2016 to 'keep people well and out of hospital in partnership'.

7. COMMUNITY INVOLVEMENT

7.1 Health and social care providers are grateful to Healthwatch Reading for their in depth work with Reading's ex-Gurkha community to identify and start to understand some of the issues raised. Through its membership of the Reading Integration Board, Healthwatch Reading will have a key role to play in keeping the patient / user perspective central to discussions as the Action Plan is progressed.

8. LEGAL IMPLICATIONS

8.1 There are no direct legal implications arising from this report, save in relation to the public sector equality duty as described below.

9. EQUALITY IMPACTS

9.1 All public sector bodies are under a legal duty to comply with the public sector equality duties set out in the Equality Act 2010. In order to comply with these duties, policies and services should be developed with a view to preventing discrimination, and also protecting and promoting the interests of 'protected' groups. Ex-Gurkhas can properly be considered 'protected' as members of a minority ethnic community. The statutory services to which Healthwatch Reading's recommendations are addressed therefore have a legal obligation to consider how to respond so as to improve access to and experience of services by the ex-Gurkha community.

10. FINANCIAL IMPLICATIONS

10.1 There are no direct financial implications arising from this report. The Action Plan proposed would be delivered within existing resources.

11. BACKGROUND PAPERS

Appendix 1: *How the ex-Gurkha community access and experience health and social care services in Reading* – Healthwatch Reading, 2015

Healthwatch Reading

How the ex-Gurkha community access and experience health and social care services in Reading.

Contents

About this report

This report presents findings of an engagement project undertaken by Healthwatch Reading in 2014 with the ex-Gurkha community in Reading, to find out how they access and experience, health and social care services.

The project was commissioned by Reading Borough Council, on behalf of a consortium of local authorities in the south-east of England. These areas have experienced a significant rise in the number of ex-Gurkha residents since the UK government granted these former Nepalese soldiers new settlement rights in 2009.

More than 100 ex-Gurkhas, their wives and Nepalese community leaders gave feedback to Healthwatch Reading via focus groups, interviews and a survey.

Overall, this population said they found it difficult to access and use health and social care services, mainly because they do not read or speak English well and are not routinely offered independent, registered translators:

- 85% of the 70 people who completed the survey found it difficult to explain symptoms to doctors or other professionals on their own
- 81% are not routinely offered an independent, registered interpreter for GP or hospital outpatient appointments
- 95% are not offered an interpreter for eye sight tests by opticians
- 89% would like to be offered an interpreter for appointments.

This situation leaves the ex-Gurkha community in the unsatisfactory position of having to rely on friends, family and acquaintances to attend appointments and attempt translation for them. One ex-Gurkha, for example, described having to bring his landlord along to discuss possible cancer symptoms. In another instance, a Nepalese woman said she had yet to disclose breast and gynaecological problems to her GP, because she was accompanied to the appointment by her son.

Lack of translated written material also caused people to miss appointments and fail to complete courses of medication. One ex-Gurkha had stopped using hearing aids because he could not understand instructions to turn down the loud volume.

Based on experiences collected, Healthwatch Reading recommends commissioners and/or providers of services:

- review how to sustainably provide interpreters to the ex-Gurkha community
- review provision of translated written information, possibly to cover appointment letters, a hospital map, and advice on making complaints
- consider outreach work on ophthalmology, audiology and dental services
- continue funding English classes for the wives of ex-Gurkhas
- raise more awareness among the community of available social care services
- Healthwatch Reading also notes some early successes achieved from this project:
- NHS guidance on requesting interpreters for patients was re-issued to GPs
- an optometrist gave a talk to a Nepalese women's group on eye tests
- the Royal Berkshire Hospital produced a patient advice leaflet in Nepalese.

Background Information

Why this engagement project was carried out

Healthwatch Reading was commissioned to undertake this project by Reading Borough Council, on behalf of a consortium of local authorities in the south-east of England, which have seen a significant number of ex-Gurkhas move into their areas.

Gurkhas are Nepalese soldiers, highly regarded for their strength and bravery, who have a long history of serving with the British Army. Following a high profile campaign by the actor Joanna Lumley (whose father served as a Gurkha), the UK government in 2009 gave retired Gurkhas the right to settle in the UK.

The local authorities wanted to find out how the ex-Gurkha community access health and social care services and to disseminate these finding across the consortium. Healthwatch Reading's remit also includes engaging with diverse community groups, particularly those whose voices are not often heard.

What the ex-Gurkha community looks like in Reading

There are 2,725 Nepalese people living in Reading, according to the 2011 Census. Nepalese community leaders say this population comprises two distinct groups – migrants of working age, many with professional qualifications - and ex-Gurkhas and their wives.

Most of the ex-Gurkha community are aged 60-75 years, and come from rural areas of Nepal. They are often living in the UK without the support of adult children, who may live back in Nepal.

Many of the ex-Gurkhas' wives have low levels of Nepalese literacy, which can make it difficult to learn English.

There is a strong Nepalese community network, through the following groups:

- Reading Ex-British Gurkhas
- Reading SSAFA (Soldiers, Sailors and Airman's Families Association)
- Greater Reading Nepalese Community Association
- Forgotten British Gurkha Centre
- Reading Community Learning Centre

How Healthwatch Reading engaged with the ex-Gurkha community

A mix of engagement methods was used during April-August 2014 to obtain views:

- Initial talks with Nepalese community leaders
- Four focus groups – two for women only, and two for men only, attended by 39 people in total, with the assistance of a registered interpreter
- In-depth interviews with eight people facing particular difficulties with health or social care, with the assistance of a registered interpreter
- A paper survey, translated into Nepalese, completed by 70 people, with the assistance of community leaders and registered interpreters.

Health and social care needs of ex-Gurkhas in Reading

Community leaders described how ex-Gurkhas in Reading have a high incidence of long term conditions, including diabetes, hypertension, cardiovascular disease and gout.

Ex-Gurkhas also commonly have hearing problems, due to the noise from discharging weapons during army service, and they may also misuse alcohol.

The ex-Gurkha's wives experience a high rate of uro-gynaecological problems (such as incontinence) due to typically having many pregnancies. They also can experience mental health problems.

In Nepal there is no universal or GP health service as there is in the UK. In Nepal, prescriptions are not normally needed and many medications can be bought over the counter. Private consultations and investigations such as blood tests or scans are relatively affordable, in comparison to costs of private healthcare in the UK, and results of these are given directly to patients.

When ex-Gurkhas and their wives arrive in the UK, they are usually well-informed on arrival of the need to register with a GP. But they find it more difficult to get information about how to access NHS dentists and opticians, and also to understand which services are free or chargeable.

It is common for the ex-Gurkha community to think that doctors and other health care staff can "cure" everything and if they feel dissatisfied with their NHS experience they may choose to travel back to Nepal to seek a second opinion. They may also prefer to be seen only in Nepal for mental health issues, sensitive issues like gynaecological problems, or to see faith healers.

Many ex-Gurkha families in Reading are on lower incomes. Some live in crowded, sub-let housing and may not be able to afford heating. Living in poor housing can increase the risk of poor health e.g. respiratory problems.

Community leaders are not sure how many people are unidentified carers looking after spouses who are frail or unwell. Community leaders believe there are some frail older widows or widowers who may not receive any kind of social care support.

The Reading Community Learning Centre runs an "English for Health" course for Nepalese-speaking woman aimed at helping them access NHS services and giving practical information on preventative and self-help care, such as healthy eating and over-the-counter medications. Nepalese-speaking volunteers also run weekly benefits advice sessions at the charity Communicare, and twice a month there are drop-in sessions jointly run by the British Gurkha Trust and Department for Work and Pensions.

How the ex-Gurkha community experience health and social care

The ex-Gurkha community in Reading gave feedback on the following services:

- GPs
- Royal Berkshire Hospital
- Urgent care services: walk-in centre, 111, out-of-hours GPs
- Community opticians and NHS dentists
- Mental health services
- Social care services

GP services

Main findings:

- 85% of the 70 people in the ex-Gurkha community, who answered the survey, said they found it difficult to fully explain their symptoms to a GP without a registered interpreter assisting them.
- 89% wanted their GP surgery to offer an independent, registered interpreter for a GP appointment, rather than ask them to use a family member, a friend or an acquaintance
- 15% said their GP surgery routinely offered to arrange a registered interpreter
- 5% of respondents knew how to make a complaint about GP services
- 15% were aware how to transfer to another GP surgery in Reading.

People who attended focus groups told Healthwatch Reading they felt anxious and *"not listened to"* when they were not able to fully describe their symptoms, particularly if they were worried their symptoms might indicate a serious illness like cancer:

"I am worried that the GP doesn't understand my symptoms because I can't speak English."

"I have breast and uterus problems but I have to attend the appointment with my son to interpret, so I have not discussed them to date with the GP."

"I had to attend A&E due to ongoing abdominal pain because my GP was not listening to me."

"I feel I am not properly listened to or taken seriously by the GP."

"I had difficulty getting the GP to refer to a hospital consultant."

"I am worried whether the GP understands that we miss our families, this can cause depression and may affect our physical health."

People also described the impact of not being offered a registered interpreter:

"I had to take my landlord to the GP to be my interpreter. The next time the surgery booked an interpreter. There really isn't enough time to talk to the GP. I feel very rushed. I had some blood tests taken about two months ago but I have not received the results. I can't phone to get the results as I can't really understand. I will have to ask my landlord to call for me. I am worried that I have not been referred to the hospital."

"I made an appointment with the GP to get the results of my thyroid test but I didn't have an interpreter so I couldn't understand. I had to rebook an appointment."

"It is difficult for us to keep asking friends to interpret for us."

"No-one offers us an interpreter so we have difficulty telling our problems to the GP."

"We don't know if we are allowed to ask for an interpreter or how to ask for one, at the GP surgery."

"I have missed appointments at the GP because I didn't understand what the receptionist was saying to me."

"It is difficult to keep asking for an interpreter. People at the surgery don't seem to know about it."

"We can find it difficult to understand the different medication we are prescribed in the UK."

"I have to keep making appointments to see the GP because I don't understand why my repeat prescription has been changed."

"If there is a GP that can speak Hindi, some of us can understand, but we cannot speak that language."

CASE STUDY 1

Mr C went to see his GP complaining of persistent pain.

"I was very worried about the causes of this pain. Was it cancer or an ulcer? The GP ordered some investigations, for example a CT scan. However I had great difficulty understanding the GP when I had the appointments at the surgery to discuss the results of the investigations. I had to use friends and acquaintances from the Nepalese community to interpret for me. I was worried that they are not able to interpret accurately as they may not understand the medical terms. I would prefer to be offered a registered interpreter by the GP surgery."

Mr C did not feel able to ask the GP practice staff for an interpreter. Healthwatch Reading asked the surgery to record his request for a registered interpreter on his electronic records. The GP surgery agreed to do this.

CASE STUDY 2

Mr R cares for a family friend, Mr L, who has several long term conditions. Mr R was worried that one of Mr L's regular medications on repeat prescriptions had recently been changed.

"I have been to the GP six times. I am worried that they have stopped medication X and how it will affect Mr L. The GP has not given me an explanation why."

Healthwatch called Mr L's surgery and the practice manager investigated, contacted Mr R and offered an appointment to explain the changes.

The community also raised more general concerns about GP services:

"Each time I visit I see a different doctor."

"We are confused about whether we can request to see a male GP."

"It can take weeks to see a GP."

"Some GPs don't have enough expertise."

"GPs need more resources."

CASE STUDY 3

Mr S has diabetes.

"I have not had an eye check for nearly two years."

Healthwatch Reading called the practice manager, who investigated Mr S's concerns. It appeared that Mr S had not understood that he had to book the appointment himself. The practice manager offered Mr R an appointment at the surgery to assist him with making the appointment.

Community leaders also said they had made complaints about one GP practice in Reading over how people were treated when first trying to register.

"Rude, unhelpful GP practice reception staff."

"Discrimination."

"Poor attitude."

The ex-Gurkha community also shared some positive experiences of GPs:

"I got a letter to have a smear test. I didn't understand it but I took it to a GP and it was done with no problems."

"I was able to understand the GP's explanation in Hindi that I was experiencing the symptoms of the menopause."

"The telephone interpreter service at the GP surgery is very useful and important."

Royal Berkshire Hospital

Main findings:

- 81% of people attending an outpatients appointment had not been offered an independent, registered interpreter
- 60% of people admitted as an inpatient had not been offered a registered interpreter during their hospital stay
- 100% of all people seen at the hospital found it difficult to fully explain symptoms to a doctor because of the lack of an interpreter
- 83% of people did not know how to make a complaint about hospital services.

The ex-Gurkha community was particularly dissatisfied with the ophthalmology (eye health) clinic:

"I had an RBH appointment last year, for eyes. Nurse couldn't understand me and there was no interpreter there. I had to go home and made another appointment through my friend."

"I didn't understand why the consultant at the hospital told me to use eye drops, so I only used them a couple of times."

"Can hospital appointments for cataracts be given more quickly?

CASE STUDY 4

Mr T was experiencing severe difficulties with his vision. He was very dissatisfied with the care he was receiving to diagnose and treat these difficulties.

"I have been waiting too long. I have been nearly blind in one eye for two years. My GP didn't listen to me. A Nepalese nurse who works at the hospital helped me to talk to the GP. The hospital sent me an appointment at the eye clinic but they cancelled it and gave me an appointment six weeks later. My children in Nepal are really worried."

Healthwatch Reading provided Mr T with advocacy support, by calling the hospital's PALS team. Mr T was offered an earlier appointment at the eye clinic. However, Mr T decided to bring forward his holiday in Nepal and instead seek treatment with an ophthalmologist in Nepal.

People in focus groups also raised concerns about lack of interpreters at the audiology clinic, where ex-Gurkhas often need to be seen for hearing loss related to their military careers:

"He was given hearing aids but the volume was very high. Couldn't get it right as he couldn't understand instructions so he stopped using the hearing aids."

Difficulties in reading English also had an impact on appointment attendance and understanding results:

"We have to get someone to translate the hospital letters for us."

"If the letter says hospital, we think it means the Royal Berkshire Hospital. Sometimes it isn't, so we miss appointments."

"People miss hospital appointments because the letter is not translated into Nepalese."

"The GP sent me to the physiotherapist who referred me for an MRI scan at the Royal Berkshire Hospital. I am worried that there won't be anyone to interpret for me at the scan as my friend is busy. I don't know how I will get the scan results – who will tell me that?"

"At the hospital my husband had a chest x-ray. They said it was abnormal. When we went home the hospital staff told us to book another chest x-ray. I don't know how to do this. Who can help with this?"

A variety of other issues were also raised about interpreter services:

"The interpreter...was not aware of the medical terms being used."

"We don't need an interpreter for routine appointments like blood tests or x-rays. We need them there for discussions about results."

"We don't know if we are allowed to ask for an interpreter or how to ask for one at the hospital."

Some people said it was easier to get an interpreter at the hospital than their GP:

"It is easier to get an interpreter at the hospital compared to the GP."

"The hospital arranged an interpreter by phone."

Feedback about tests results and waiting times reflected a lack of understanding by ex-Gurkhas of how the NHS did things differently to Nepal's health system:

"Why were the x-ray and scan results sent to GP and not given direct to us?"

"I was seen by the cancer centre but I didn't receive a copy of any of their letters or scan reports."

"My wife is very anxious about the delay in having her operation."

"Can hospital appointments be given more quickly?"

Urgent care services

Main findings:

- All the focus group participants said they were aware of the 999 service
- Only a very small number were aware of the 111 service
- None of the focus group participants were aware of Westcall, the out-of-hours GP service in Reading
- More than three-quarters of those in the focus groups were aware of the Reading NHS Walk-In Centre in Broad Street Mall.
- All focus group participants were aware of the emergency department at the hospital and one in ten said they had used it since moving to the UK.

People who had used 999 said they were very satisfied with the healthcare provided by paramedics.

When Healthwatch Reading explained the 111 concept, women expressed concern that they would not be able to use it because of their difficulties speaking English.

Some of the community were registered at the walk-in centre as patients, but most people who had used the centre had done so if their own GP surgery was closed or they couldn't get an appointment. Some people said they were interested in transferring from their current GP surgery to register as permanent patients at the walk-In centre.

People who had attended the hospital's emergency department had used family members to interpret for them. One participant recalled being told by hospital staff that he should have gone to see his GP – and not the emergency department -about his chronic pain.

Focus group participants expressed concern about what could happen in an emergency situation if there weren't family of friends immediately available to interpret for them.

Community health services: opticians and dentists

Main findings:

- 81% of the ex-Gurkha community surveyed said that they wore glasses
- 26% said they had diabetes
- 36% had not yet had an eye test in Reading
- 88% had difficulty explaining their sight problems
- 95% were not offered a registered interpreter for an eye sight test
- Only 38% had had an NHS dental check-up
- Only 25% had had NHS dental treatment

Like other health services, eye and dental services are difficult for the ex-Gurkha community to access, because of language barriers.

Focus group participants said they experienced particular difficulties using community ophthalmology services (eye sight and eye health checks at opticians). They were also generally confused about the route to eye and dental professionals, and what care was free or chargeable:

"I was worried about my eye sight but I found it difficult to get help because of language difficulties. I went to A&E and they referred me to the eye clinic at the RBH."

"I don't understand how to use their [opticians'] service to get an eye sight test."

"I get confused about whether I have to pay for my eye sight test. Last year I had a free test but this year, Tesco's asked me to pay."

"When visiting the opticians I needed a relative to support and interpret in order to do the eye test and I needed glasses."

"Not always clear where dental services are and when they are open."

"I don't understand what dental treatment is covered by the NHS."

Mental health and dementia services

Main findings:

- 13% of the focus group participants described themselves, their spouse or friend as having mental health difficulties
- 3% of focus group participants had used the NHS Talking Therapy service
- No-one in the focus groups had heard of Mother Tongue, a counselling service in Reading for people from ethnic minority communities
- 5% of focus group participants were aware of the term, 'dementia'

Healthwatch Reading heard conflicting views about mental health needs: Nepalese community leaders and workers described a high level of mental health difficulties, particularly among women. However in the focus groups, women were very reluctant to talk about mental health or stated that it was not an issue:

"Our mental health is fine."

The ex-Gurkhas were more open about discussing mental health difficulties:

"Worries about family members who are living in Nepal cause us stress."

"My wife is very anxious and worried about our disabled daughter in Nepal."

Some people suggested GPs were not supportive of mental health difficulties:

"One lady who is a widow sought mental health help back in Nepal. Her GP [in the UK] was not helpful."

"My friend who had mental health problems wasn't looked after properly by his GP."

Most of the ex-Gurkha population in Reading are aged over 60. However the low awareness of the term 'dementia' suggests they might not be aware of the local diagnostic and support services available for people with dementia.

Travelling back to Nepal to use healthcare services

Main findings:

- 31% of those surveyed have had an eye sight test in Nepal during a trip back, at least once since moving to the UK
- 8% of focus group participants had travelled back to Nepal for treatment of cataracts because they feel waiting times are too long in the UK
- People have also travelled back to Nepal for women's health consultations, a scan or x-ray, or treatment for depression

The differences between the Nepalese health system (where patients have more direct access to specialists, tests and medication) and the NHS (where the GP plays a 'gatekeeping' role to secondary care), can cause the ex-Gurkha community to feel anxious or dissatisfied with NHS care. This often results in people using trips back to Nepal to see family as an opportunity to also access healthcare:

"I am thinking about going back to Nepal for my eye sight. I can just go to the eye hospital in the city and get seen there by a specialist doctor on the same day, if I pay."

"I had liver checks and a scan of my abdomen in Nepal."

"I went back to Nepal to get help with a women's health problem, so I could properly talk to the doctor."

"Often quicker to fly back to Nepal to pay to get treatment than to wait on the NHS."

Social care services

Main findings:

- Most focus group participants were not aware of the term 'carer'
- Some vulnerable adults in the ex-Gurkha community do not appear to be receiving any social care support at all
- Some people are dissatisfied with the service from home care agencies.

During focus group discussions, the ex-Gurkha community seemed unaware of the term 'carer' (a person who provides unpaid support to an unwell relative or friend to help them live their life). When Healthwatch Reading explained the definition of a carer, 13% of the focus group participants said they regarded themselves as carers and they also described other carers that they knew of locally.

Several participants expressed concerns that some ex-Gurkhas who need help are not receiving social care services:

"There is an 84-year-old man. He had violent behaviour. The family are not receiving any help."

"One lady receives no care services other than support from the community and friends."

"There is a widow who lives alone who needs care services but doesn't get any."

Around 10% of the focus group participants and interviewees were users of home care services or had friends who did so. They described some dissatisfaction with the quality of home care services due to cultural and language barriers:

"We don't like to use home care services because they don't speak Nepalese."

"We prefer to care for our family members ourselves as we speak the same language. If it got too much we would ask for help."

"Home care agencies need to be better able to help ex-Gurkhas to have the type of food that they are used to."

"The carers often come late. One carer watches TV, another spends all the time on the phone. I would like to ask if one particular carer can stop coming and maybe change carer's agency. However we have been told that we could lose our carers allowance or pension credits if we complain about a carer or our carer's service."

The ex-Gurkha community made some suggestions about improving access to social care services:

"Want to know more about carers allowance and carers support service."

"Provide information about home care companies who provide Nepalese speaking carers."

"Better distribution of the (translated) booklet about services for carers. Make it more clear and understandable."

Healthwatch Reading's recommendations:

The ex-Gurkha community gave a very clear message during this engagement project that they were prevented from properly accessing health and social care, due to a combination of not understanding or speaking English well, and not being routinely offered independent interpreters. The differences between the UK and Nepalese health systems also led to some dissatisfaction with the NHS.

Healthwatch Reading makes the following recommendations:

1. GP practices in Reading (in partnership with their commissioners), should review how they can sustainably provide interpreters for the ex-Gurkhas and their wives who need assistance explaining their symptoms and needs during consultations.
2. Community dentists and opticians (in partnership with their commissioners), should review how they can sustainably provide interpreters for the ex-Gurkhas and their wives who need assistance explaining their symptoms and needs during consultations.
3. The Royal Berkshire Hospital, particularly ophthalmology and audiology clinics (in partnership with their commissioners), should review how they can sustainably provide interpreters for ex-Gurkhas and their wives who need assistance explaining their symptoms and needs during consultations.
4. Reading's two clinical commissioning groups should consider providing ex-Gurkhas and their wives with an information card that they can show health service staff to indicate that they wish to have an interpreter arranged for their appointment.
5. GP practices in Reading should review the written information they regularly provide to the ex-Gurkha community to identify whether any of this information – such as appointment letters– should be translated into clear and simple Nepalese. Consideration should also be given on providing translated information on making a complaint, and how to changing GP practices.
6. The Royal Berkshire Hospital should review the written information they regularly provide to the ex-Gurkha community to identify whether any of this information – such as appointment letters, the hospital map, should be translated into clear and simple Nepalese.
7. Community dentists and opticians in Reading should review the written information they regularly provide to the ex-Gurkha community to identify whether any of this information – such as appointment letters – should be translated into clear and simple Nepalese.
8. Staff from the Royal Berkshire Hospital's ophthalmology and audiology clinics, should consider undertaking outreach work with the ex-Gurkha community to raise awareness of how to access and use their services and to set expectations on issues such as waiting times.
9. Staff from community eye test and NHS dental services, should consider undertaking outreach work with the ex-Gurkha community to raise awareness of how to access and use their services and to set expectations on issues such as waiting times and any costs.
10. Reading Borough Council should raise awareness among the ex-Gurkha community of free support available to carers and also raise awareness among frontline social care staff of potential unmet needs of vulnerable people within this community and how these might be addressed.
11. Reading's two clinical commissioning groups to continue to support Health English for Health language classes for Nepalese women, and consider developing these classes to include access to mental health and social care services.

How organisations are acting to address the issues

During this engagement project many initiatives were started in a bid to overcome the problems the ex-Gurkha community face. Some of these initiatives were directly as a result of Healthwatch Reading raising issues with services or commissioners, and included:

- The NHS England (NHSE) Thames Valley local area team wrote to all GP practice managers in Reading, reminding them that the NHSE funds on behalf of all practices, an interpretation service via Reading Borough Council, and set out the process for practices to follow to arrange interpreters in advance of appointments, or in emergencies, for patients.
- An optometrist from the NHSE Thames Valley local area team attended a session with the Gurkha Ladies English Project, to talk to the women about NHS optometry services. This included information on how an eye sight test can be done without using the English alphabet.
- The NHSE Thames Valley local area team wrote to community optometry providers (opticians) in Reading to inform them of the feedback from the ex-Gurkha community, about the need for interpreting for eye sight checks and explaining how to arrange interpreting services via Reading Borough Council.
- Royal Berkshire Hospital's PALS (patient advice and liaison team) produced a Nepalese language version of their leaflet for patients and carers.
- The Reading NHS Walk-In Centre said it was planning to hold an information and coffee morning for their Nepalese speaking patients informing them about the NHS.
- Healthwatch Reading itself produced a Nepalese leaflet about its NHS Complaints Advocacy Service.

In addition, Healthwatch Reading attended a regional conference on ex-Gurkha health and wellbeing and heard an example of good practice at Frimley Park Hospital in Surrey, where Nepalese-speaking hospital staff are trained as interpreters and released from their usual hospital jobs as needed, to work as interpreters for ex-Gurkha patients.

During the project, the SSAFA Gurkha Ladies English Project also produced a new booklet, *Your health and wellbeing*, which provides information in a clear and simple style with both English and Nepalese text, and images and photos on all pages. The project teachers have developed a weekly teaching programme using the booklet, to further improve Nepalese women's understanding of the information about healthcare services. The printing costs for the booklet were funded by the Public Health department at Reading Borough Council.

Reading's CCGs told Healthwatch Reading that they had previously raised concerns about the needs of this group of patients and have held a workshop for GPs to raise awareness of the ex-Gurkhas' healthcare needs.

The CCGs added they had agreed to await the outcome of Healthwatch Reading's final project findings to "help us understand the specific areas we need to focus on. Any progression with this needs to be in collaboration with other partners such as Reading Borough Council and Reading Voluntary Action, to ensure a joined-up approach."

While NHS England commissions interpretation services on behalf of GP practices for their patients, translation services for hospital patients are funded differently – in Reading, by the local hospital trust, Royal Berkshire NHS Foundation Trust.

Royal Berkshire Hospital staff told Healthwatch Reading:

"Interpreters are booked for patients identified as needing language support (by either the GP or by the patient or relative/representative).

"For first appointments, this should be notified by the GP. A flag is then put on the patient's electronic patient records (EPR) to alert any future staff booking future appointments, that an interpreter in that language is needed.

"We use Prestige Network interpreters who request preferably at least two weeks' notice. However, they will try and provide face-to-face at shorter notice if available.

"All departments have access to telephonic interpreters (again with Prestige Network) and there are several three-way handsets around the trust for specific telephonic interpreting use.

"Instructions about booking interpreters are available on our Intranet and there are posters and leaflets for staff explaining when and how to book interpreters. Posters encouraging patients to request an interpreter (in 17 languages, including Nepali) if required are also available throughout the trust and posters are also displayed informing patients that they can request written information in different languages or formats if required."

Healthwatch Reading has also identified that it possibly needs to undertake more engagement work with the ex-Gurkha community to discuss in more detail, mental health, dementia, and social care, and their use of community pharmacy services.

Formal responses to report

Response from NHS England Thames Valley area team

GP SERVICES

NHS England currently commission a translation and interpretation service for patients registered with GP practices in West Berkshire (and beyond). Reading Borough Council is the current provider and co-ordinate any request from practices for the service. They provide a wide range of languages including Nepalese and can provide this either face to face or by telephone, whichever is appropriate. Patients requiring this service just need to ask at their surgery and it will be arranged.

NHS England became aware of a problem accessing the service last year which, on investigation, appeared to result from a change in personnel at RBC. The service was quickly clarified and all practices were contacted to remind them of what is available for their patients and how to access the service.

Project Manager (interim), General Medical Services

DENTAL SERVICES

Patients are not registered with dental practices so can attend where they choose. NHS Choices provides useful information about the location of dental practices in relation to people's home address. Facilitation in the use of NHS Choices may be helpful.

NHS Choices also provides information about dental charges and the treatments provided within those charges. Each of the dental practices provides leaflets which describes their services and confirms charging arrangements (which are national in terms of NHS fees).

The Choices website does provide information in a range of other languages, but it does not appear that Nepalese is one of them so this is something that could be taken up at national level as this issue is unlikely only apply to Reading.

If patients need treatment in a hospital, fall into the special care category (such as learning disabilities) or need orthodontic treatment (up to the age of 19) they will be referred by their dental practices.

If patients do not have access to a dentist for continuing care and experience dental pain they can contact NHS 111 who will signpost them to a practice who will be able to provide treatment. NHS 111 will also signpost patients to dental out of hours services.

If service providers are aware that patients will have challenges around communicating in English they can call upon the support of the Reading Interpretation service.

The report appears to highlight issues in terms of trying to navigate around the NHS when language is a key challenge. It would be useful to consider how this is done on a co-ordinated basis so that support is given to the community to understand how to access services and the materials that are available in all the services described, are available in Nepalese (which could include support in using electronic communications).

Contract Manager – Dental

OPTOMETRY SERVICES

Patients are not registered with an optician and can choose which one they wish to attend. NHS Choices provides useful information about the location of opticians near to their home addresses. NHS Choices also provides information about eligibility to NHS Sight tests and the frequency of NHS sight test and eligibility for vouchers to help with the costs of glasses. Each optician provides leaflets which describes their services and confirms charging arrangements (which are national in terms of NHS fees).

If service providers are aware that patients will have challenges around communicating in English they can call upon the support of the Reading Interpretation service. All opticians in the Reading area have been updated on the process for arranging an interpreter from the Reading Interpretation service.

The report appears to highlight issues in terms of trying to navigate around the NHS when language is a key challenge. It would be useful to consider how this is done on a co-ordinated basis so that support is given to the community to understand how to access services and the materials that are available in all the services described, are available in Nepalese (which could include support in using electronic communications). The Eye Health Local Network Chair attended a meeting in June with the ex-Gurkha community leaders to explain access to eye care and eligibility to NHS Eye services in conjunction with Healthwatch Reading as part of an engagement project undertaken by Healthwatch Reading with the ex-Gurkha Community in 2014 .

Assistant Contracts Manager, Pharmacy and Optometry

Response from Royal Berkshire NHS Foundation Trust

Dear Healthwatch Reading

Thank you for forwarding the report 'How the ex-Gurkha community access and experience health and social care services in Reading'. I have shared it with the Directors of Nursing and with the relevant departments highlighted within the report. The Royal Berkshire NHS Foundation Trust (RBFT) recognises the social and cultural diversity of the communities we serve and we are committed to providing equal access to our services for all our patients. To this end we employ Prestige Network as our interpreting company and we advertise that interpreters (and translations of any patient leaflets) can be made available to patients in all our outpatient and inpatient areas.

I understand that Kiran has already forwarded you the interpreting poster (which is in English and the top 17 languages requested for interpreting at the RBFT, including Nepalese) and the translation poster (in English and 7 top languages, again including Nepalese). Of course, these rely on the Nepalese community being able to read their own language and if they are already attending the ward or department they can only take this information on board for future visits. As with all new patients we do rely heavily on the referrer indicating that the patient needs language support so unless the GP/dentist/optician flags this up, it means that a Nepalese interpreter may not be booked for first appointments. However, a telephonic interpreter can be used on these occasions if the appointment allows. Our website does have a Nepalese version of our 'Talk to us' leaflet for download **www.royalberkshire.nhs.uk/patient-information-leaflets/Talk%20to%20us%20Nepalese.htm** which outlines how to raise concerns and make a complaint. I am happy for the ex-Gurkha community to make this leaflet available on **www.rebga.co.uk/** if you think that would be helpful. There is also a statement in Nepalese on the general information leaflet pages of the website explaining that translations can be made available upon request (via our PALS Department). I have contacted the team responsible for the Electronic Patient Records (EPR) system with regards to your enquiry about appointment letters in different languages. The Assistant Director of Application Support reports that currently the only facility within EPR for any language provision other than English is a flag for the need for an interpreter. There is no facility within the system to identify whether a patient has requested correspondence in a different language nor is there any obvious way of storing multiple versions of any letter in a different language. I am aware however that certain department (such as Audiology) do regularly get appointment letters translated when patients require this but unfortunately this does depend on the individual resources and timescales available within different departments. However, given that the Trust sends out approximately 15,000 new outpatient appointments per month I'm sure you understand that this is an issue that cannot be easily addressed.

It would be impractical to get the 'Find your way' map translated into Nepalese as it is mainly a list of departments and locations and there would be no corresponding translated signage on the hospital site (and there are no plans to introduce multilingual signage). A signage group, led by Philip Holmes, Director of Estates and Facilities is currently looking at introducing some new accessible signage measures such as using colour and icons (which will be tied in to appointment letters) which will be soon available for public consultation. I will ensure the ex-Gurkha group will be involved when this happens. Is there someone in particular at REBGA who would be a point of contact for this? The Audiology and Ophthalmology Departments have composed their own responses to the recommendations regarding the ex-Gurkha community. These are as follows: Audiology are looking at a possible awareness day – taking the mobile hearing unit to the coffee morning **www.rebga.co.uk/coffee-programme/** and offering hearing screening as a one off event. They are also creating a short leaflet outlining the services available and will have this translated into Nepalese with a view to putting it on the Trust website and sending to the Reading ex-Gurkha website. Staff have been reminded in Clinical Governance (27/01/15) of the resources available for people who need interpreters or require leaflets to be translated. All patients who require an interpreter are entitled to have one. Staff have access to the 'Identify your language' sheet to check what language patients require. Staff must offer an interpreter and the patient must sign a waiver if they decline. Interpreting booking guidelines, forms and waivers are all available to download from the Trust Intranet **http://nww.intranet.royalberkshire.nhs.uk/clinical_care/patient_relations/interpreting__translation.aspx**.

There is some handy information for Audiology staff in the folders on f:drive under language and accessibility. This includes things which we have already had translated into different languages. F:\Language and Accessibility The Phonak Software allows staff to print off basic hearing aid instructions in a number of languages. Staff can also print 'Communication Tips and Strategies' (hearing tactics) and 'Care and Maintenance' but this is quite limited. Translations can also be done via the Trust's interpreting service Prestige Network. Ophthalmology (Eye Clinics & Eye Casualty) have recently hosted a visit from HealthWatch with regards to improving services for the ex-Gurkha community and I understand the matron and sister for the area are awaiting one further visit and some more detailed recommendations following that visit. The matron confirms that the unit will be happy to participate in any awareness events such as coffee mornings in order to explain the current referral processes and waiting times and thus hopefully better manage patient expectations.

All staff in the unit have been reminded of the processes for booking interpreters and arranging translations when required but again we do rely on the initial referrer letting us know when a patient needs an interpreter for their first hospital appointment. I hope this response addresses some of the concerns raised in the report and reassures the ex-Gurkha community that the Trust is happy to work with them to clarify current care pathways, promote language support and manage service expectations.

Jane Burnett, Patient Information Manager

Response from NHS South Reading CCG and North West Reading CCG

We are responding on behalf of the NHS South Reading CCG and North West Reading CCG in response to the above report which we received on 13th January. This is a very useful report which provides the CCGs with a helpful understanding of the issues and experiences faced by the Nepalese community which is a small but growing population accessing translation and interpretation services in Reading. We welcome the opportunity to work with our local partners and make improvements to our services and we would like to thank you and the Nepalese community for drawing this to our attention. The commissioning and delivery of interpretation and translation services is complex in Reading; NHS England has the responsibility for commissioning translation and interpretation services for primary care and these are provided by Reading Borough Council. Royal Berkshire Foundation Trust provides its own service. We will ensure our response is shared with these partners so that we can work together, where appropriate, in response to the primary care recommendations. We are committed to engaging as widely as possible with the various language groups represented in the population of Reading and recognise the need to provide improved and tailored communications for the Nepalese Community in order to allow them to access NHS healthcare services in the most appropriate way. Our response to the specific recommendations in the report is as follows:

GP practices in Reading (in partnership with their Commissioners), should review how they can sustainably provide interpreters for the ex-Gurkhas and their families who need assistance explaining their symptoms and needs during consultations.

Issues around the accessibility and effectiveness of interpreters for this community was raised with GPs. GPs were interested to hear about the experiences of the ex-Gurkha community and keen to make improvements. Three GPs indicated they have a significantly higher population of ex-Gurkhas and two suggested that some of their patients might be willing to be trained and act as interpreters on behalf of other members of the community. The two GPs are Dr Nadeem Ahmed from Melrose House Surgery (nadeemahmed2@nhs.net) and Dr Anil Sagar from London Road Surgery (asagar@nhs.net). I will pass these details to Reading Borough Council and NHS England to progress. This could also help to address another issue raised by GPs around the need to have more Nepalese interpreters.

Reading's CCGs should consider providing ex-Gurkhas and their families with an information card that they can show NHS staff to indicate they wish to have an interpreter arranged for their appointment.

The CCGs recognise the benefits of an information card and will discuss with partners via the CCG Patient Engagement Group, of which Healthwatch is a member, an action plan to progress this. Reading GP practices in should review the written information that they regularly provide to the ex-Gurkha community to identify whether any of this information – such as appointment letters – should be translated into clear and simple Nepalese.

Consideration should also be given on providing translated information on making a complaint and how to change GP practice.

The CCGs will share the content of this report and our response with our GP practices so that they are aware of the recommendation to translate letters. GPs have been reminded about the process for booking an interpreter and using the translation services. Practices have also been asked to check with their reception desk staff so they are also clear on the process. GPs will again be reminded that trained interpreters should be offered rather than members of the family fulfilling this role. This topic will also be covered in our next GP newsletter. We think that communications around interpretation and translation may be more effective if directed via the CCG, and we will work with NHS England to arrange for this. Surgeries receive information from a range of sources, including a few from CCGs. The CCGs will consider a standard phrase, via the Patient Engagement Group, directing patients how to arrange translations of CCG produced written information.

Reading's CCGs to continue to support Health English for Health language classes for Nepalese women, and consider developing these classes to include access to mental health and social care services

The CCGs have previously funded these courses through the Partnership Development Fund (PDF) grant, however, no application has been received for 2015/16. We welcome bids from the voluntary sector and should this organisation wish to apply for future funding, it will be considered.

Yours Sincerely

Dr Rod Smith, [formerly] Chair NHS N&W Reading CCG and Dr Ishak Nadeem Chair NHS South Reading CCG

Response from Reading Borough Council

Background

In 2014, Healthwatch Reading was commissioned by Reading Borough Council, on behalf of a consortium of local authorities in the south-east of England, to explore how the ex-Gurkha community access health and social care services and to disseminate these finding across the consortium.

Gurkhas are Nepalese soldiers who have a long history of serving with the British Army. Following a high profile campaign, in 2009 the UK Government gave retired Gurkhas the right to settle in the UK. The local authorities which commissioned this project have seen a significant number of ex-Gurkhas move into their areas since this time. The 2011 Census indicated that Reading had a Nepalese population of 2,725. This includes migrants of working age, many with professional qualifications, and then ex-Gurkhas and their wives. Most of the ex-Gurkha community are aged 60-75 years, and come from rural areas of Nepal. They are often living in the UK without the support of adult children, who may live back in Nepal.

More than 100 people from the ex-Gurkha community in Reading gave their feedback on accessing health and social care services for this study, including

- GPs
- Royal Berkshire Hospital
- Urgent care services: walk-in centre, 111, out-of-hours GPs
- Community opticians and NHS dentists
- Mental health services
- Social care services

The main findings of the project in relation to social care services were:

- Most focus group participants were not aware of the term 'carer'
- Some vulnerable adults in the ex-Gurkha community do not appear to be receiving any social care support at all
- Some people are dissatisfied with the service from home care agencies.

Healthwatch Reading recommendation to Reading Borough Council

Reading Borough Council should raise awareness among the ex-Gurkha community of free support available to carers and also raise awareness among frontline social care staff of potential unmet needs of vulnerable people within this community and how these might be addressed.

Reading Borough Council response

Reading Borough Council produces a range of information materials about social care both online and in printed copy, as well as commissioning community groups to help people to navigate the care system.

One of the most comprehensive information packs the Council's Adult Social Care service produces is the 'Caring in Reading' guide to local services for anyone who is providing unpaid care to a family member, friend or neighbour. This pack was first translated into Nepalese in 2012 to support Nepalese Health Week, and Adult Social Care staff attended this community event to help raise awareness of social care amongst the Nepalese attendees and take questions. The pack remains available in Nepalese, although recent demand has been more for individual sections than for the pack as a whole.

It is a challenge to find the right words to connect with people providing unpaid care, and 'carer' does not translate easily into all languages because of different cultural norms. Clearly Healthwatch Reading was able to describe 'carer' to the focus group participants as 13% went on to identify themselves as carers as well as going on to describe other members of their community as carers. This illustrates the importance of face to face contact and discussion in providing effective support to navigate care services, and the Council will use this feedback to inform its future commissioning of information and advice services.

The Council will also be reviewing its products and distribution channels for social care information in 2015, and within this will endeavour to address the focus group participants' comments, i.e.

"Better distribution of the (translated) booklet about services for carers. Make it more clear and understandable."

"Want to know more about carers allowance and carers support service."

The intention is to seek feedback from a number of user/public reference groups to inform this review. In the light of Healthwatch's findings, the Council commits to recruiting an ex Ghurka reference group to take part in this review and provide interpreter support as required.

Reading Borough Council provides the Interpretation and Translation service referred to in the Healthwatch report, which primary healthcare partners can also access. The Council will aim to improve awareness of this service through its partnership working, including the quarterly Adult Social Care partner newsletter, *Care Junction*.

We note the comment made within the focus groups that people wanted the Council to:

"Provide information about home care companies who provide Nepalese speaking carers."

As part of bidding to join the new Homecare Framework (HCF), providers were asked to demonstrate they could provide high quality home care services in Reading in line with the needs of Reading's diverse communities. This including ensuring providers have a suitable workforce with a ride range of skills, understanding and communication skills in order to offer appropriate support to individuals with difference preferences and needs. The Council worked with Healthwatch Reading and a user panel in setting the questions for this bidding process and then scoring answers.

Providers who were successful in their bid to join the Framework demonstrated that they recruited within local communities based on local demographics and individual needs such as language and cultural background. At least 3 of the providers on the new HCF have informed commissioners that they have carers who can speak Nepalese. The Council will compile a language audit of all agencies on the HCF and to make this available to individuals upon request and (in the longer term) monitor the ethnicity of individuals needing care and feedback any specific requirements to providers via the Home Care Forum.

Promoting wellbeing and preventing people's support needs from worsening is a cornerstone of Adult Social Care's approach, and our Public Health colleagues play a key part in this. The Public Health service within Reading Borough Council can provide several health and wellbeing leaflets in Nepalese via Solutions 4 Health. There is also a trained smoking cessation / Eat4Health Advisor who can communicate in Nepalese and she is targeting the ex Ghurka community. Public Health has also worked with the Clinical Commissioning Groups in Reading to co-fund a new general healthcare booklet, *Your health and wellbeing*, which provides information in a clear and simple style including English and Nepalese text but also clear images so that the booklet can be used by people with relatively low levels of literacy.

We are grateful to Healthwatch Reading for this in-depth study and look forward to working with them in future to improve our understanding of and reach into the ex Ghurka community.

Melanie O'Rourke, Interim Head of Adult Social Care, Reading Borough Council

Project summary

More than 100 people in the ex-Gurkha community in Reading have described their difficulty in accessing health and social care services, because they cannot speak or understand English well and are not routinely offered interpreters. This leaves them needing to use friends, family and acquaintances as interpreters, which in turn can prevent them from discussing particularly intimate or private symptoms with health professionals, or fully understanding treatment options or medication instructions. Some action has been taken to start to address some of these issues, however Healthwatch Reading urges commissioners and providers to consider and act on all its recommendations to fully meet the needs of this group.

Acknowledgements

Healthwatch Reading thanks all the ex-Gurkhas, their wives, and the Nepalese community leaders and workers who contributed to this project. In particular, Healthwatch Reading thanks the Reading Community Learning Centre, the Gurkha Ladies English Project and the Forgotten British Gurkha Centre, which kindly hosted focus groups, community meetings and interviews.

Healthwatch Reading
3rd Floor, Reading Central Library
Abbey Square, Reading
RG1 3BQ
Tel 0118 937 2295
info@healthwatchreading.co.uk
www.healthwatchreading.co.uk

@HealthwatchRdg
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Healthwatch Reading

Annual Report

2014/2015

Contents

Note from the Chair

Healthwatch Reading chair David Shepherd

I am pleased to introduce our second Annual Report. During 2014-2015, we received a record number of contacts – more than 400 - from members of the public. The top three issues we continue to hear about are: GP services, making up 31% of the 400 contacts, followed by 21% about hospital services and 11% about mental health services. These have all increased against last year. We also ran more engagement activities, talking to those whose voices are seldom heard, such as the ex-Gurkha community.

Our key projects for the year included an investigation into delayed transfers of care, which led to a new action plan, signed up to by local NHS and social care leaders. Our report was also submitted to Healthwatch England's special inquiry into Unsafe Discharge.

We are pleased to have influenced a home care commissioning framework, in ongoing partnership with Reading Borough Council. This included direct service user involvement in scoring contract bids. We also worked with a local charity to train three people with learning disabilities as Enter and View representatives. And we developed a toolkit and training for patient participation groups.

Another key success was winning the local NHS complaints advocacy contract from 1 April 2014, which gives us further insight into how people experience care. A further contract, on advocacy under the Care Act, has been won for 2015-16.

I would like to take this opportunity to say a word of thanks to Sheena Masoero for all her hard work and dedication. Inspired by her Healthwatch work, she left to go back to the NHS frontline. Thanks must also go to one of our trustees, Linda Dobraszczyk, who left to lead a major project in public health - she brought a wealth of experience and knowledge. We also welcomed a new trustee, Gurmit Dhendsa, who brings invaluable experience in managing organisations, and new board member Shaheen Kausar, chair of South Reading Patient Voice. Our staff team welcomed Catherine Williams, with her wide experience from chairing the local Maternity Services Liaison Committee. Finally I would like to thank all our partners and local community for their support in making this a successful year.

About Healthwatch

We are here to make health and social care better for ordinary people. We believe that the best way to do this is by designing local services around their needs and experiences.

Everything we say and do is informed by our connections to local people and our expertise is grounded in their experience. We are the only body looking solely at people's experience across all health and social care.

We are uniquely placed as a network, with a local Healthwatch in every local authority area in England.

As a statutory watchdog our role is to ensure that local health and social care services, and the local decision makers, put the experiences of people at the heart of their care.

Our mission

Our mission is to campaign for better care for our community. We do this by:

- *Advising* people of their rights, giving them information, and signposting them to other services;
- *Advocating* on behalf of local people to raise concerns, make a complaint or support them to have their voice heard;
- *Actioning* by listening hard to people, especially the most vulnerable, to understand their experiences and what matters most to them, and influencing those with the power to change things, now and in the future.

Our strategic priories

Our priorities are based on what the community says is important to them and are driven by the Healthwatch Board.

They focus on the following key areas:

1. **People are empowered to share feedback, complain or have their voice heard** – we will work with individuals in our local community, the local voluntary and community sector, as well as statutory partners, to gather local people's views and support them in having their voice heard. This year our focus was on working with our new and emerging Nepalese ex-Gurkha community, older people affected by delayed transfers of care and those using maternity services.
2. **Ensuring everyone has an equal voice** – we will work with the diverse community of Reading to understand how they experience local services. This year we have a focus on people with learning difficulties and older communities.
3. **People are involved in shaping services for today and the future** – we will work within and create networks to ensure more people are involved in shaping services and ensure that providers and commissioners follow their duty to involve people in shaping services. This year we have focused on working with PPGs to support them in creating a more active and sustainable network.

Our people

Healthwatch Reading's staff team is passionately committed to securing better health and social care for the people of Reading.

Healthwatch Reading staff are DBS-checked to ensure they pose no risk to vulnerable adults they meet and talk to in the community. They are also trained in Level 1 safeguarding, so they are aware of how to refer any suspected cases of abuse of vulnerable people to the local authority's safeguarding team.

Healthwatch Reading staff are trained on how to use statutory 'Enter and View' powers when visiting and observing health or social care services in action, such as A&E departments or care homes.

All our staff team in 2014-15 gained qualifications in providing NHS complaints advocacy.

Staff team

Chief executive: Mandeep Kaur Sira

Advocacy services lead: Merlyn Barrett

Communications lead: Rebecca Norris

Officers: Catherine Greaves; Catherine Williams

Healthwatch Reading staff also follow a number of policies covering compliance with the Data Protection Act (1998), lone working, handling crisis calls, and meeting duties of the Equalities Act (2010).

In particular, Healthwatch Reading and its people are committed to:

- promoting equality of opportunity;
- celebrating and valuing diversity; and
- eliminating unlawful, direct and indirect discrimination.

The staff team follow a work plan set by a board of members of the community.

Engaging with people who use health and social care services

Understanding people's experiences

Healthwatch Reading organised or took part in nearly 100 different engagement events and activities that reached out to more than 3,000 individuals and groups, including some of the most vulnerable and disadvantaged in our community.

The 43 different events and activities that we specifically led gave more than 1,100 people the opportunity to talk in-depth about their experiences of health and social care services.

These engagements included:

- drop-in sessions at a number of libraries, local GP surgeries, supermarkets and malls;
- joint events with voluntary sector partners; and
- focus groups with local parent and family groups, people with learning difficulties, community groups, carers groups, children's centres, bereavement forums and focus groups specifically for the local Nepalese ex-Gurkha community.

Healthwatch Reading also took part in 53 activities or events organised by partners, which gave us the opportunity to promote our work and speak to more than 1,800 local people about their concerns and experiences. These included:

- Older people's working group
- Carers information events
- Social worker training sessions
- Community festivals
- Mental health service user groups
- Polish community event
- Learning disability groups
- Youth Cabinet
- Working carers forum
- Maternity services forum
- Family forums
- PPG meetings

Healthwatch Reading aims to engage with the community as a whole and this includes the most disadvantaged, those who are vulnerable and isolated, ethnic minorities, and young people. This year we undertook a specific project focusing on understanding the access needs of our local community of ex-Gurkhas. Over the last few years Reading has seen a growing Nepalese community move to the area and concerns have been raised about how they access and experience health and social care services. This project involved a number of focus groups with the community and we spoke with more than 100 ex-Gurkhas and their wives. We learned language was the biggest barrier and the lack of availability of interpreters inhibited their use of services. More details of this engagement can be seen in a case study later in this report.

We now have more than 1,000 followers on Twitter which means we can engage quickly when needed

In addition to our work with the ex-Gurkha community we have worked with another vulnerable group – frail elderly people - through our focused piece of

work on delayed transfers of care out of hospital. We conducted in-depth interviews in order to understand how this group could experience services better.

We also met and worked with Reading Youth Cabinet this year to ensure we are listening to the views of young people locally and to present them with our final report on a survey of 170 secondary school pupils who gave their views about accessing specialist school nurses. We also extended our work with children by beginning to hold focus groups in Children's Centres and working with family forums to understand the needs of children with special needs in our community that are high users of health and social care services.

We also try to engage with those who may use services in Reading but who may not live in the area and ensure that their views are captured. We have gathered views from local volunteers through community events and networks and through drop-in sessions at the Reading NHS walk-in centre. However there is more work for us to do to capture the views of those who commute to Reading for work.

Our monthly newsletter, sent out to our 650-strong reference group is a regular source of engagement through which we ask the public to complete our own surveys as well as give feedback on consultations run by our local NHS or social care providers, or government.

We used the online survey tool, Survey Monkey, to ask the public about GP access. And by the end of 2014-15 we also had more than 1,000 followers on Twitter. We find this an invaluable method of reaching working age adults, the media, local decision-makers, community groups, and MPs, particularly if we need to spread word quickly during fast-paced changes.

Enter & View

All of our staff team are authorised Enter and View representatives and led three E&V projects during the year:

Eye clinic at Royal Berkshire NHS Foundation Trust

Two visits to the Eye Clinic were prompted by consistent complaints received from the community about long waits for appointment dates. A separate engagement project carried out with the ex-Gurkha community also raised concerns about the Eye Clinic. The project was also an extension of partnership working with the trust's outpatients experience programme. The trust will use some of the E&V findings to inform staff training on issues such as body language. The Healthwatch Reading board has requested a repeat future visit to check for improvements.

Circuit Lane Surgery in Southcote, plus two care homes and children's centre used by surgery patients

These multiple E&V visits were driven by public concerns about how the changeover of management would work at the surgery.

A mass resignation of the surgery's GPs had been averted when Berkshire Healthcare NHS Foundation Trust was appointed to take over on a temporary basis, but many vulnerable, housebound patients were left very unsettled and anxious by the changes.

BHFT has pledged to continue to listen to feedback collected by Healthwatch Reading and the PPG to inform the surgery's longer term future.

Various wards at RBFT, to look at the experience of inpatients with learning disabilities

This project was driven by Healthwatch Reading's mission to involve, value and collect feedback from, people whose voices are seldom heard.

In particular, Healthwatch Reading joined forces with the voluntary sector to train three people with learning disabilities, and a board member, as Enter and View representatives, so they could give their own insight into the experience of people with learning disabilities who had been admitted as inpatients on various wards at RBFT. The three new representatives also undertook an adapted Level 1 safeguarding workshop. An existing partnership between the trust's learning disabilities liaison nurse and Healthwatch was also crucial to the project.

RBFT have agreed to the team undertaking one or two similar visits per month on an ongoing basis. The trust has also been urged to consider introducing a communication picture book for staff to use when talking with inpatients with learning disabilities.

Providing information and signposting for people who use health and social care services

Helping people get what they need from local health and social care services

Providing information, advice, signposting and advocacy accounts for 50 per cent of Healthwatch Reading's work.

The top three areas we provided information and advice on were:

- GP Services
- Hospital Services
- Mental Health Services

Case Study

Information, advice and signposting to unpaid carers

Mr Smith and his wife stopped at a Healthwatch Reading stand set up at a community information event. He said he was concerned about how he and his wife, and his siblings, would cope in the longer term trying to look after his mother, who was in her 90s and had been recently discharged from hospital after a fall. The couple had already put off a planned holiday and they didn't know when they would next get a break. Healthwatch Reading informed Mr Smith of his right to request a carer's assessment from the council, gave him the telephone number for the council's adult social care contact team, and also gave him details of the local carers' information and advice service. The council offered Mr Smith help in arranging a respite break in a local care home for his mother and also approved a carer's grant of £150 that he could spend on a leisure activity to ease his caring responsibility.

Case Study

Information and advice to patient about GP referrals

Miss Jones phoned Healthwatch Reading to query whether her GP had acted properly in delaying her request for a referral to hospital for surgery until she had lost weight. Miss Jones wanted the surgery for osteoarthritis and was concerned that her GP might be fobbing her off. A Healthwatch Reading officer researched and found guidelines from the National Institute for Health and Care Excellence about surgery referrals for osteoarthritis, and also found the Thames Valley Priorities Committee guideline for doctors on osteoarthritis. These both showed that doctors should give patients advice about exercise and losing weight before considering surgery. Miss Jones said she felt reassured by knowing about the guidelines as it showed her GP was not

treating her any differently to anyone else and she would now concentrate on efforts to lose weight.

Our advocacy work

On April 1st 2014 Healthwatch Reading was awarded the contract to provide advocacy services for those who wish to raise a concern or make a complaint about a NHS service.

Healthwatch Reading was already providing low-level advocacy support for local people, and by taking on complains advocacy we believed we could offer a seamless service; both in terms of preventing concerns escalating into formal complaints, or supporting people right through from initial point of contact to resolution, rather than passing on people mid-way through the process to an external advocacy organisation where they would have to tell their story again.

Our staff team gained City and Guilds qualifications in advocacy in preparation for this new strand of work.

In that first year we provided advocacy for 50 complaints cases and low-level advocacy support for 70 cases.

People came to us with a wide variety of concerns, as broken down below:

Complaints

Category	number
Royal Berkshire Hospital NHS Foundation Trust (RBFT)	24
GP Services	9
Mental health	9
Dentist	2
Other	2
NHS England	1
South Central Ambulance Service (SCAS)	1
Westcall (out-of-hours GP service)	1
Berkshire Healthcare NHS Foundation Trust (community services)	1
Total	**50**

Low-level advocacy

Category	number
GP Services	25
RBFT	9
Adult Mental Health	5
Dentist	5
Social Care	5
Child and adolescent mental health services (CAMHS)	3
NHS continuing healthcare	3
Clinical commissioning group	2
Care home	1
Commissioning support unit	1
Home care	1
Public Health	1
SCAS	1
Transport	1
Miscellaneous	7
Total	**70**

Complaints case studies

Securing a second opinion after a hospital local resolution meeting

Mrs Cook was referred to Healthwatch from another advocacy organisation about an historical complaint about surgery she had received 10 years previously. She did not believe she had given consent for procedures carried out during the surgery at Royal Berkshire NHS Foundation Trust and she believed these were behind ongoing symptoms since, which had caused her distress. The previous advocacy organisation had supported Mrs Cook in writing a complaint letter to the hospital and she finally received a response in early 2014, which she was dissatisfied with.

A Healthwatch Reading advocate met with Mrs Cook and talked through her various options, to help her decide how to proceed. Mrs Cook was keen to get an explanation of the surgery that was conducted and the previous treatment that she had received for her condition, and she also wanted a second opinion on her surgery and her condition and what further treatment may be needed, in order to deal with her daily distress.

Healthwatch Reading spoke with the hospital about arranging a local resolution meeting (LRM) for Mrs Cook with the lead surgeon. The advocate worked with Mrs Cook to help her list her concerns in detail, and sent these ahead of the meeting, and supported Mrs Cook to speak for herself at the meeting and ensure that her voice was heard.

The outcome of the meeting was very positive; Mrs Cook was given an appointment for a second opinion within a month, and the surgeon also apologised for the distress that had been caused.

Helping a mother get a quicker autism assessment for her child

Mrs Baker came to Healthwatch Reading very concerned about her two-year-old daughter. She had been worried about her child's development for the past 12 months and health and education professionals had suggested possible autism. A GP had referred her children for an assessment for autism.

Since the referral Mrs Baker had been given conflicting information about how long she would have to wait for an assessment – ranging from eight to 18 months and all which she found unacceptable. In particular she wanted reassurances that her child would be assessed before her 3rd birthday.

> 'It's a shame we had to complain to get it happen but it is wonderful that my child will be assessed and we can start getting all the right support in place for her.'

A Healthwatch Reading advocate met with Mrs Baker at her home and helped her write a complaint letter to Berkshire Healthcare NHS Foundation Trust. Within two weeks, Mrs Baker's child had been seen by a clinical psychologist on a home visit and then been given an appointment for a full assessment. Her child went on to be diagnosed with autism.

Mrs Baker gave positive feedback about the support she had received from Healthwatch Reading in getting her concerns resolved. The doctor who visited her child also acknowledged that the complaint had resulted in learning for GPs, and child and adolescent mental health services staff.

‘Low-level’ advocacy case studies

Arranging home visit for housebound older person with concerns

Mrs Matthews was referred to Healthwatch Reading by her local councillor. She is very elderly and is the primary carer for her husband, who is also elderly and frail. She told Heath watch on the phone that the week before she had had a fall in her home. A paramedic came to assist and advised her she would need her GP to come and check on her later. Mrs Mathews phoned the GP surgery that day and was told she would get a home visit at the end of the day but the GP had not come any time since the call. Mrs Matthews was also concerned about medication that her GP had stopped prescribing recently, as she had noticed swelling in her ankles.

Healthwatch called the surgery and spoke to a receptionist who said that Mrs Matthews had not turned up to appointments at the hospital falls clinic. Healthwatch explained that because Mrs Matthews was housebound, she was unable to attend such appointments and queried what other options were available. A phone call was arranged between Healthwatch and Mrs Matthews’ GP.

The GP agreed to restart the medication, sending out an emergency prescription, and also agreed to ask the district nurse to arrange a domiciliary occupational therapist assessment.

The GP also agreed to look into referring Mrs Matthews to adult social services for a carer’s assessment for support in her role looking after her husband.

Alerting ward staff to issues about ‘next-of-kin’ notes on records

Mr Stephens contacted Healthwatch Reading in the hope of improving procedures for future families of very ill inpatients. His mother had recently passed away in hospital and due to some kind of mix-up on the day, ward staff did not have a phone number to hand to alert Mr Stephens that his mother’s condition had deteriorated. The next time he rung to check on her condition he was told that she had died a short time earlier.

Mr Stephens explained that he might not have been able to get to the hospital even if he had been contacted in time, but he wanted someone to look into what happened so other families would not be affected in the same way in the future.

Healthwatch raised Mr Stephen’s concerns with the hospital’s patient advice and liaison service (PALS). A matron sent back a very strong apology and explanation about how the next-of-kin contact had been incorrectly recorded when the patient was first admitted. In the future, staff would check contact numbers when they arrived on wards from the emergency department.

Mr Stephens said he was satisfied with this response and he did not feel it necessary to raise a formal complaint.

The matron’s apology and explanation about what would happen in the future was a good enough response and meant he didn’t need to make a formal complaint

Influencing decision makers with evidence from local people

Producing reports and recommendations to effect change

The workplan for 2014-15 was set by the Healthwatch Reading board, based on what local people had been telling us about services.

The main projects completed during the year were:

- a major engagement exercise with the ex-Gurkha community into how they experience health and social care services, that revealed problems accessing interpreters and understanding hospital letters
- an inquiry into how local women who are diverted away from maternity services at our local hospital experience services, which revealed that women want more practical information about hospitals they are diverted to
- in-depth interviews with people (or carers) affected by a delayed transfer of care out of hospital, which unearthed system-wide problems
- an online survey on how local people experience GP services, which indicated dissatisfaction with the system for booking appointments by telephone first thing in the morning
- the development of a toolkit and training for local PPG groups.

These projects have gone on to influence how services are being developed and commissioned, as the case studies outlined next, show.

Case study: An action plan to address delayed transfers of care

Healthwatch Reading's in-depth interviews with mostly older, frail people (and/or relatives and carers) revealed that people were dissatisfied with the hospital discharge process. They were given inadequate or delayed information about how to find nursing or care homes and discharge was sometimes halted at the last minute because of failure by services to confirm if ongoing care was in place. The interviews also revealed there were missed opportunities to prevent hospital admissions, particularly from sheltered housing or care homes, where some people had experienced serious or multiple falls.

The hard hitting, anonymised stories were shared with a private, convened meeting of health and social care leaders, who were urged to jointly address the issues raised.

In response, those leaders drew up and signed a wide ranging action plan, which was included in Healthwatch Reading's report. The plan includes a commitment to giving patients an estimated discharge date within 24 hours of their arrival, and rewriting the joint health and social care policy on transfers of care, clarifying responsibilities of staff members from all agencies and the timescales for action. The plan also highlights a new 'discharge to assess' scheme to allow more time for assessments about people's long term nursing or social are needs.

Healthwatch Reading has gone on to share one of the key project findings - 'Dorothy's story', about an elderly woman with no family, whose care fell between the many service gaps, at public meetings and also the West of Berkshire Safeguarding Adults Board.

Case study: Meeting the needs of the ex-Gurkha community

Healthwatch Reading engaged with more than 100 ex-Gurkhas, their wives and Nepalese community leaders via focus groups, interviews and a survey.

The key findings were that 85% found it difficult to communicate symptoms to health professionals, and a similar number were not routinely offered interpreters for appointments.

> 'We don't know if we are allowed to have an interpreter or how to ask for one at the GP surgery.'

Before Healthwatch Reading's final report was published, its project had already generated some early success in improving care for this community. This included:

- re-issuing of guidance to GPs on how to request interpreters
- an optometrist giving a talk to a Nepalese women's group on eye tests
- the hospital producing a patient advice leaflet in Nepalese.

Reading's two clinical commissioning groups welcomed the report and have suggested a new initiative in which local GPs with higher numbers of ex-Gurkha patients would identify willing patients ready to be trained as interpreters for others. The CCGs would also discuss the possibility of introducing an information card that Nepalese people could show NHS staff if they needed an interpreter.

Reading Borough Council also committed to action – including informing people about local home care agencies that had Nepalese-speaking care workers. Members of the Ex-Gurkha community would also be invited (with interpreter support) to a public panel reviewing council information materials and websites.

Representation on the Health and Wellbeing Board

We have used our statutory seat on the Reading Health and Wellbeing Board to raise the issues we are hearing from our local community and ensuring the patient voice is heard and consulted on in key decision making.

We have presented our key reports, including the report on Delayed Transfers of Care.

Our representative on the Board has been involved with workshops and development and planning sessions undertaken by the Board and will be involved in the review of the effectiveness of the Board in the coming year.

Our representative also attended an internal workshop, held by a former journalist for all Healthwatch Reading board members, on dealing with the media and speaking in open meetings.

Working with others to improve local services

We are committed to working with local partners, from providers and commissioners, and voluntary sector organisations to affect change. In doing so we have developed good partnership working models with them.

The three case studies below highlight our success in working with partners.

Influencing a home care commissioning framework

The co-production of a home care commissioning framework by Healthwatch Reading and Reading Borough Council was the culmination of a partnership project first launched more than two years ago.

Staff from both organisations had jointly interviewed more than 60 home care service users and discovered six key areas for improvement.

Throughout 2014-2015, the two organisations discussed how to shape the new criteria that home care agencies would have to satisfy, if they were to secure a place on a new list of approved providers for 2015-2019. A group of service users was invited to the council to review the draft criteria, which covered areas such as better support planning, rota planning, staff values and communication skills. Agencies would also be expected to pay staff a 'living wage', pay for travel time, and to sign up to a local dignity charter.

The council's commissioning team also agreed to a Healthwatch Reading request that one of its staff members, and a local service user, be involved in helping to score bids that the council had received from 18 home care agencies. This essentially involved being 'locked down' in a council room for a day to systematically assess and jointly debate with commissioners, the scores that should be awarded.

The involvement of a service user was crucial to this process, as she pointed out discrepancies in some of the anonymised support plans the agencies submitted, as well as describing what she would consider good practice. She also argued for wider action to be taken to improve the quality of support plans across the board, and the council will work with agencies to advance this work.

Putting the patient voice at the heart of GP practice procurement

Healthwatch Reading developed a productive relationship with NHS England's area team at the end of 2014 to ensure patient interests were represented during the process to select a new provider to take over a local practice – Circuit Lane Surgery in Southcote. GPs who had previously run the practice had tendered their resignations due to challenges with recruitment, premises and finances and many patients only found this out first from the local press.

After Healthwatch Reading spoke out publically and strongly in defence of patients worried about lack of information and continuity of care, NHS England invited a Healthwatch Reading representative to take part in weekly talks with a councillor, MP, and health officials, to try and find a solution.

A rapid process to procure a temporary new provider was then launched, which involved Healthwatch Reading setting some of the contract criteria, stipulating continuity of care safeguards for vulnerable patients.

Healthwatch Reading also took part in the joint assessment and scoring of bids, informed by the surgery's patient participation group, and was able to endorse the chosen provider – Berkshire Healthcare NHS Foundation Trust. BHFT has since actively encouraged Healthwatch Reading's ongoing involvement in collecting patient feedback after the transition.

Joining forces with the voluntary sector on bereavement care

On 5 November 2014, Healthwatch Reading hosted the inaugural meeting of a local bereavement forum, which had grown organically from informal discussions with voluntary sector colleagues who were keen to pool ideas, knowledge and resources to improve the care of people affected by death and loss.

That first meeting was attended by nearly 20 people from organisations including charities who offer counselling, funeral directors, NHS and council staff, the Coroner's Court Support Service and academics.

Ideas at the first meeting included trying to make it easier for people to talk about 'taboo' subjects of death by suicide or miscarriage, and also supporting people who are grieving not over a death, but potential lost life, such as parents of children who receive certain diagnoses. Future meetings will aim to widen the network to include faith leaders.

Working with other local Healthwatch

Healthwatch Reading has been a key driver in bringing together local Healthwatch across the Thames Valley. We now meet on a quarterly basis to look at common concerns in our region, discuss policy issues as well operational issues and each member acts as a representative of the Thames Valley at key meetings.

Healthwatch Reading is also a member of the Berkshire Healthwatchs group, which again meets on a quarterly basis and receives support from Berkshire Healthcare Foundation Trust in order to facilitate this meeting.

Woking with national partners

This year we did not make any formal recommendations or escalate any issues to the CQC or Healthwatch England. We have been able to work locally to raise and resolve issues of concern.

However we have shared our reports and learning with the CQC and Healthwatch England, including our report on delayed transfers of care, which fed into the HWE's special inquiry into Unsafe Discharge.

Our plans for 2015/16

Opportunities and challenges for the future

Our plans for 2015/16 will build on our work in the second year of Healthwatch Reading; we will focus on the following areas of work:

- Following a number of CQC inspections in the area and increase in contacts we receive about primary care along with the changing landscape in commissioning, we will take a major focus on primary care.

- We will aim to better understand the experience of inpatients at our local mental health facility through an Enter and View visit.

- We will take a special focus looking at how GPs and primary care can better support the recognition of carers and their access to support.

- We will provide more training for local PPG members in order to support the development of these networks in providing feedback for our local community.

- We will build on our advocacy services and have trained up more staff members in order to provide this increasing area of our work. In addition to this, from April 2015, Healthwatch Reading will provide the brokerage and co-ordination for the new Care Act advocacy service in Reading.

- Finally we will look to widen volunteering within in all streams of our work and organisation. Supporting this area of work will continue to ensure that local people remain at the heart of Healthwatch Reading's work.

Our governance and decision-making

Our trustees and board

Our trustees

Monica Collings – Social Care

Linda Dobraszczyk – Public Health and mental health services

David Shepherd (chair) – Commissioning of Services and primary and acute care

Gurmit Dhendsa – financial and strategic development

Our board

Sheila Booth – Physical Disabilities and Sensory Needs

Douglas Findlay – Young People and Pharmaceutical Services

Tony Hall – Care for the older and elderly and GP services

Sue Pigott – Learning Disabilities

Reverend John Rogers –Engagement with the Faith community and Social Care

Linda Dobraszczyk – Public Health and Mental Health

David Shepherd – Commissioning of Services

Helena Turner – Community Engagement, Young People and Mental Health

Carol Munt – Public and patient involvement

Tilly Corless – Wellbeing of young adults, especially students at the University.

Co-opted Members

Bernard Dominic – Chair of North and West Reading CCG Patient Voice

Shaheen Kausar - Chair of South Reading CCG Patient Voice

How we involve lay people and volunteers

Our board and trustees are all volunteers and members of the local community. The trustees are responsible for the strategic vision of the organisation and its governance. The trustees are also responsible for raising funds in order to fulfil the workplan. The Board are responsible for the workplan and ensuring that we are listening to our local community, responding and ensuring change is happening. We also involve our local community in decision making about our workplan. Before the Board decides what to focus on we ask our local community via our newsletter and a call out to our reference group about the issues that are of concern to them. Along with the information we collect from our contacts and the intelligence from the Board, the Board then compiles the workplan for the year. We also involve volunteers in our project work and Enter and View visits, including student volunteers. This year we have involved 40 volunteers in the work of Healthwatch Reading.

Financial information

INCOME	£
Funding received from local authority to deliver local Healthwatch statutory activities	130,311
Additional income	98,664
Total income	228,975

EXPENDITURE	
Office costs	20,500
Staffing costs	105,359
Direct delivery costs	11,016
Total expenditure	136,875
Balance brought forward	92,100

Contact us

Get in touch

Address: Healthwatch Reading, 3rd Floor Reading Central Library, Abbey Square,

Reading, Berkshire, RG1 3BQ

Phone number: 0118 937 2295

Email: info@healthwatchreading.co.uk

Website URL: www.healthwatchreading.co.uk

We will be making this annual report publicly available by 30th June 2015 by publishing it on our website and circulating it to Healthwatch England, CQC, NHS England, Clinical Commissioning Group/s, Overview and Scrutiny Committee/s, and our local authority.

We confirm that we are using the Healthwatch Trademark (which covers the logo and Healthwatch brand) when undertaking work on our statutory activities as covered by the licence agreement.

If you require this report in an alternative format please contact us at the address above.

READING BOROUGH COUNCIL

REPORT BY DIRECTOR OF ADULT CARE AND HEALTH SERVICES

TO:	**HEALTH AND WELLBEING BOARD**		
DATE:	**17 JULY 2015**	**AGENDA ITEM:**	**10**
TITLE:	**INTEGRATION UPDATE**		
LEAD COUNCILLOR:	**COUNCILLOR HOSKIN**	**PORTFOLIO:**	**HEALTH**
SERVICE:	**ADULT CARE**	**WARDS:**	**ALL**
LEAD OFFICER:	**MELANIE O'ROURKE**	**TEL:**	**0118 937 4053**
JOB TITLE:	**INTERIM HEAD OF ADULT CARE**	**E-MAIL:**	**Melanie.o'rourke@reading.gov.uk**

1. PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1 The Better Care Fund (BCF) became operational from 1st April 2015. NHS England has now supplied guidance on the role of the Health and Wellbeing Board (HWB) and how the BCF should be monitored and reported on.

1.2 The timing of this report did not allow for a local interpretation in advance of the last HWB. At the HWB Board on 17 April 2015 it was agreed that this would be reported on at the Board meeting on 17 July 2015.

1.3 At the previous Board the issue of a variance in the local non elective target (NEL) was also discussed. As the submission of which sat outside of the HWB cycle, delegated authority was given to the Director of Adult Care and Health Services review and submit the local figure. This report informs the Board of the agree figure that was submitted to NHS England.

1.4 It would also appear timely for the HWB to be appraised of early indications as to the impact of the local BCF scheme, Discharge to Assess, which is described by the use of a case study later in the report.

2. RECOMMENDED ACTION

2.1 Actions requested from the Board:

a) For the HWB to note its responsibility for monitoring and reporting on BCF performance, including the technicalities of reporting to NHS England;

b) For the HWB to approve delegated authority for the Director of Adult Care and Health Services in consultation with the Chair of the HWB to approve BCF performance submissions outside of the HWB timetable;

c) To confirm the revised non-elective target submitted to NHS England on 15th May; and

d) For the Board to note early indicators of the impact of the Discharge to Assess Scheme as described in the case study.

3. BCF OPERATIONALIZATION

3.1 Each HWB locality is required to submit a quarterly performance return to NHS England.

3.2 The return focuses on our progress against BCF national conditions (with narrative if achieved / on track) and the agreed key performance indicators from our original submission (e.g. figures in relation to changes in non-elective admissions, permanent admissions into residential care, reduction of number of people on the "Fit to Go" list at any one time).

3.3 The table below describes the National and Local Performance indicators:-

National Indicator	
Indicator	**Description**
Protecting Social Care	Universal services Whole family approach, including domestic violence, mental health, substance misuse, transition from Children's to Adults Services
Care Act	Care Act national eligibility Funding reforms Eligibility Information, advice and advocacy Safeguarding responsibilities Market failure
Carers	Joined up local offer Including access to support packages Carers assessments Information and advice for carers
7 day access	GP access Night wardens Access to rapid response service to reduce admission into the acute hospital setting
Data sharing	Universal use of NHS numbers IT connectivity
Engagement	Call to action events Care Act consultation Engagement with providers and voluntary sector organisations

Local Indicator	
Indicator	**Description**
Reduction of Non Elective admissions into hospital	Hospital at Home Service Robust Rapid response service Data sharing
Reduction of the number of people on the "fit to go list"	Discharge to assess, both within the Willow's and the community through the Community Reablement Service
Reduction of the number of days an individual is on the "fit to go list" to no more than 5 days	As above
Reduction of admissions into residential care homes	Discharge to assess
Service user satisfaction	7 day access, carer support, information and advice

3. 4 A local process and reporting suite have been developed through the Integration Finance Delivery Group (a table of which can be found in Appendix A).

i. The dates for the NHSE returns are:

Quarter	Period	Submission date	HWB date
Q1	April – June 2015	28 August 2015	9 October 2015
Q2	July – September 2015	27 November 2015	22 January 2016
Q3	October – December 2015	26 February 2016	18 March 2016
Q4	January – March 2016	27 May 2016	July 2016

4. THE PROPOSAL

4.1 It is necessary for the chair of the HWB to agree with the quarterly return prior to its submission. It is recommended that this authority is delegated outside of the formal meeting structure, in collaboration between the CCG, Director of Adult Care and Health Services and the Chair of the HWB. This will ensure timely submissions.

4.2 It is also recommended that the HWB receive regular progress reports regarding the performance of the Better Care Fund as requested from the Board.

5. NON ELECTIVE ADMISSION PERFORMANCE FIGURE

5.1 At the HWB on 17 April 2015, Board members discussed the proposal to submit a changed target for Non Elective admissions into hospital. This was in

response to the surge of activity that was experience over the last quarter of 2014 – 15.

5.2 The HWB on 17 April 2015 approved delegated authority to review the revised figure with the Clinical Commissioning Group and submit. The final figure submitted was an increase of non-elective activity of 3.3%.

5.2 It is accepted that for the Health and Social Care system to see an increase in activity into hospital rather than a decrease of activity could have an adverse impact on the demand for long term services such as care packages in people's own homes or people moving into care homes. The Council expressed the risks that this might create, and has asked that the activity into the hospital as well as the activity experience by the local authority can be closely monitored.

6. UPDATE ON DISCHARGE TO ASSESS SCHEME

6.1 The Discharge to Assess service went live with a soft launch from 1 April 2015.

6.2 As previously described the focus of the scheme is to facilitate timely discharge from hospital to either a community setting, or a bed based setting at The Willows (Wil's).

6.3 It is anticipated that through comprehensive Multi-Disciplinary Team assessments, individuals will receive the most appropriate services to meet long term needs. The anticipated benefits of this service is a reduction in long terms admissions into care homes, and an increase in the number of people that are able to return to their own home of into extra care housing schemes.

Below describes a case study of someone who is experienced the Discharge to Assess Service:

Mrs A is 91 years old. She has sensory needs (hearing and sight). Prior to admission into hospital with a fractured leg, Mrs A was living with her son independently.

Mrs A moved from the hospital setting to the Willows Discharge to Assess Service. This gave her the opportunity to promote independence relating to her mobility and her ability to transfer. The team worked with Mrs A to determine how she would cope if she were to return home.

Once the plaster and leg brace were removed Mrs A was able to weight bear and she worked with the team to become independent. It was also identified that Mrs A would benefit from an assessment from the Sensory Needs Team to see if there was any equipment that could assist her independence. Mrs A was able to return home with no ongoing care needs.

If Mrs A had returned home with a package of care, she may have continued to have long term care needs through restricted mobility.

To return home with no ongoing care needs illustrated the effectiveness of the new service.

7. FINANCIAL IMPLICATIONS

7.1 The report set out that the implementation of the better care fund is in the initial stages and that there will be a requirement for the Council and partners to report on financial and activity information to the Department of Health on a quarterly basis.

7.2 The report also highlights that there has been a change to the expected target for Non Elective admissions into hospital. This has been increased and is therefore at variance to the original BCF plans. The issues for the partners are that whilst the change has been driven due to an increase in patient numbers this does have an impact on:

- The level of performance that has to be achieved for the performance fund to be awarded; and
- That additional cost may fall on partners.

7.3 The report identifies that these factors will need to be monitored and included in future quarterly performance reports to the Health and Wellbeing Board.

8. BACKGROUND PAPERS

Appendix A - performance and reporting arrangements

APPENDIX A **PERFORMANCE AND REPORTING ARRANGMENTS**

Partners recognise the need for a robust performance and reporting framework for delivery of the Better Care Fund schemes (BCF) and the wider Integration programme. The performance and reporting framework will ensure that parties have visibility and assurance relating to local progress in delivering BCF priorities and the impact on national metrics and local Key Performance Indicators (KPIs). The framework will also provide assurance to any regional or national scrutiny.

Key Control documents, reporting levels and production responsibility

Locality/Programme Level Reporting				
Item	Document(s)	Description	Production	Audience
1	Monthly Status Report	An overall Status report which includes the progress against milestones made and issues effecting delivery/running of local BCF Schemes utilising a Red, Amber, Green (RAG) Status. The report to include the following sections: Part 1 – reporting on the progress or delivery of each of the BCF schemes using the agreed RAG formula. Part 2 – Financial Statement – actual and forecast spend against scheme and programme allocation Part 3 – Key scheme milestones and critical dates Part 4 – Scheme Risk and Issues	Locality Programme Manager & Pooled Fund Manager/s	Reading Integration Board & BCF Scheme Steering Groups HWB Board
2	Risk Register	Strategic level risk register	Locality Programme Manager & Pooled Fund Manager/s	
3	Financial Report	Monthly financial reports on the actual spend and forecast for each of the Schemes/ Programmes against the financial allocation in the Better Care Fund Plan. Reporting will make reference to overspending and underspending schemes and any financial implications linked to 'pay for performance' metrics to support parties in the decision making process and inform any remedial actions needed.	Locality Programme Manager & Pooled Fund Manager/s	
4	BCF Performance Dashboard	Performance will include progress against nationally and locally prescribed metrics. The performance dashboard will include commentary with headline information on a scheme by scheme basis highlighting the impact on metrics, namely: • Reduction in permanent residential admissions. • Increased effectiveness of re-ablement. • Reduction in delayed transfers of care. • Reduction non-elective admission to hospital. • Patient / Service User experience. • Any other metrics arising through changing national conditions, or locally agreed by all parties. • Exception commentary where 'red' risks have been highlighted.	Locality Programme Managers with support from BW10 PMO and CSCU Informatics	

READING BOROUGH COUNCIL

REPORT BY DIRECTOR OF CHILDREN, EDUCATION & EARLY HELP SERVICES

TO:	**Health and Wellbeing Board**		
DATE:	**17 July 2015**	**AGENDA ITEM:**	**11**
TITLE:	**Update report on Information Sharing work being taken forward by the LSCB**		
LEAD COUNCILLOR:	**Cllr Jan Gavin**	**PORTFOLIO:**	**Children's Services**
SERVICE:	**Children's Services**	**WARDS:**	**All**
LEAD OFFICER:	**Esther Blake**	**TEL:**	**X73269**
JOB TITLE:	**Business Manager for Reading LSCB and Children's Trust Partnership**	**E-MAIL:**	**Esther.blake@reading.gov.uk**

1. PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1 A joint letter from Government Ministers, dated 3rd March 2015, was sent to all Chief Executives, Directors of Children's Services, Local Safeguarding Children Boards and Health and Wellbeing Boards. It follows the publication of the Government response to the child sexual exploitation cases in Rotherham and states that a key factor in keeping children safe is the effective sharing of information.

1.2 This letter was discussed at the Reading Local Safeguarding Children Board (LSCB) on 5th March, with actions agreed to review the existing Information Sharing Protocol and produce a revised document.

1.3 The Health and Wellbeing Board were asked to note the contents of the Ministers letter and sign up to the principles it contained at the meeting on 17th April 2015.

1.4 This is a brief update report to the Health and Wellbeing Board, on the progress of the LSCB Information Sharing Task and Finish Group.

2. RECOMMENDED ACTION

No action required; report is for information only.

3. REPORT

3.1 The LSCB Information Sharing Task and Finish Sub Group met for the first time on 5th May 2015. Much of the session was spent agreeing the remit of the group and clarifying the need for a clear protocol.

3.2 There was unanimous agreement that CSE is a current high risk area and the need for a clear information sharing protocol on this topic was vital to support front line staff to make appropriate decisions.

3.3 A draft document has already been produced in West Berkshire, so the group will review this with a view that moving towards a West of Berkshire or Pan Berkshire approach would be beneficial for many agencies that span more than one local authority/LSCB area.

3.4 The LSCB held a challenge session looking specifically at CSE on 2nd June 2015, and this again confirmed the need for clear information sharing processes specific to this cohort of vulnerable young people. The different organisations within Health do not all use the same database, so sharing information between Health colleagues, such as details of presentations at Accident and Emergency and Health Visitors needs clarity.

3.4 The group will consider the current Reading Information Sharing Protocol against the LSCB Procedures and recent Government guidance and make any recommended changes. All partners will be asked for written agreement that they sign up to the protocol.

3.5 The group agreed that the information sharing documents being produced for the MASH should continue separately so as not to be delayed, and would likely help to inform any changes to current documentation in due course.

3.6 The group is due to meet again in the next couple of months (date to be set), with actions expected to be completed by then. A further report to the Health and Wellbeing Board can be produced at that time if required.

4. CONTRIBUTION TO STRATEGIC AIMS

4.1 This work meets the following Corporate Plan priorities:
1. Safeguarding and protecting those that are most vulnerable;
2. Providing the best start in life through education, early help and healthy living;

4.2 Plus the following Strategic Aim:
- To promote equality, social inclusion and a safe and healthy environment for all.

5. EQUALITY IMPACT ASSESSMENT

5.1 An Equality Impact Assessment (EIA) has not been carried out for this report however, equality and diversity continues to be a key theme for the LSCB.

6. LEGAL IMPLICATIONS

6.1 A protocol, signed up to by all partner agencies, must be in place to allow effective and appropriate sharing of information and data for the protection of children and young people.

9. FINANCIAL IMPLICATIONS

9.1 None

10. BACKGROUND PAPERS

- Letter from Ministers dated 3rd March 2015
- Reading Children's Trust Information Sharing Protocol

READING BOROUGH COUNCIL

REPORT BY DIRECTOR OF CHILDREN, EDUCATION & EARLY HELP SERVICES

TO:	**Health and Wellbeing Board**		
DATE:	**17 July 2015**	**AGENDA ITEM:**	**12**
TITLE:	**Reading Children's Trust Children and Young People's Plan 2015-2018**		
LEAD COUNCILLOR:	**Cllr Jan Gavin**	**PORTFOLIO:**	**Children's Services**
SERVICE:	**Children's Services**	**WARDS:**	**Boroughwide**
LEAD OFFICER:	**Esther Blake**	**TEL:**	**X73269**
JOB TITLE:	**Business Manager for Reading LSCB and Children's Trust Partnership**	**E-MAIL:**	**Esther.blake@reading.gov.uk**

1. PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1 The purpose of the Children's Trust is to hold all Partners to account for their contribution to improving the life of children who live in Reading. It provides a strategic framework within which partners can commission services together, consult with each other and agree a common strategy on how they will co-operate to improve children's wellbeing and to help embed partnership working in the partners' routine delivery of their own functions.

1.2 The latest Children and Young People's Plan (2015-18), which sets out the expectations the Trust has in priority areas identified as issues for children and families in Reading, has been endorsed by the Adult Social Care, Children's Services and Education Committee and is presented to the Health and Wellbeing Board for information.

2. RECOMMENDED ACTION

2.1 That the Health and Wellbeing Board notes the Children & Young People's Plan 2015-2018.

3. POLICY CONTEXT

3.1 In November 2010, the statutory Children's Trust (CT) guidance was withdrawn, along with the requirement on the Trust to produce a Children and Young People's Plan (CYPP). However, the duty to co-operate (Children's Act 2004) still applies to local authorities and their health, education and youth justice partners.

3.2 Following this announcement, all current CT partners were consulted regarding the value they place on Reading's CT and CYPP, and their views on whether they would chose to continue, review or disband the Trust and Plan in light of deregulation.

3.3 All partners recognised the additional value of having a Children's Trust and CYPP and committed to supporting both which led to the revised CYPP for 2011-2014, and now our latest version for 2015-2018.

3.4 The CYPP is monitored and delivered through the Children's Trust and is firmly positioned within the overall vision for the Reading contained in the Corporate Plan.

3.5 The CYPP covers services for all those in Reading aged 0 to 19, young people aged 20 and over leaving care and young people up to the age of 25 with learning difficulties. It is not a detailed operational plan therefore the CYPP will need to be underpinned by local authority and partner plans operating at different levels to accomplish specific goals and to manage delivery on a day to day basis.

4. THE PROPOSAL

4.1 Children's Trust Board members took part in a couple of dedicated sessions in 2014 reviewing data from the Joint Strategic Needs Assessment, data from the last CYPP and the priorities from key strategies and plans from partner organisations.

4.2 The results of these sessions were produced a range of areas of concern which were collated and grouped into the following three overarching priorities :

Priority 1 - Having the best start in life and throughout

- Ensure that children and young people are empowered and informed to make positive life choices
- Enable children and young people to build emotional wellbeing and improve health
- Work to ensure that those using our services have as positive an experience as possible and are able to influence future service delivery
- All young people have access to an equitable universal offer across the area.

Priority 2 - Learning and employment

- All children and young people have a fair and equal chance to achieve, and have access to information to make informed decisions about their future, regardless of heritage, income or disability

Priority 3 - Keeping children safe

- Protect and safeguard ALL children and young people and in particular those that need our care. This includes protection from others (in particular, domestic abuse, sexual exploitation, on-line abuse and cultural abuse) and protection from harm they may cause themselves (in particular, self harming)

4.3 These priorities form the basis of the new CYPP. The CYPP starts by detailing the local context, linking clearly to the Reading Borough Council Corporate Plan, the contribution made by the Youth Cabinet, plus the vison and values of the Children's Trust.

4.4 Each priority is described in more detail, detailing for each, 'What do we know?', 'Examples of current activity across the partnership', 'Some of the things that are happening in the first year', and 'How will we know we are making a difference?' With this plan we have continued to improve performance management by focusing on a smaller number of priority measures.

4.5 It is important to recognise that this plan cannot be read or delivered in isolation: it is intrinsically linked to other key strategies and plans either written, or in

development. These have been listed in the CYPP, against each priority, on pages 6 and 7.

4.6 The CT Board signed off this CYPP on 1st April 2015 and partners will be taking it through their respective organisation boards for endorsement. The Adult Social Care, Children's Services and Education Committee endorsed the CYPP at their meeting on 29th June 2015.

5. CONTRIBUTION TO STRATEGIC AIMS

5.1 This report contributes to the Council strategic aim of Narrowing the Gap and two of its service priorities:

- Safeguarding and protecting those that are most vulnerable and;
- Providing the best life through education, early help and healthy living.

6. COMMUNITY ENGAGEMENT AND INFORMATION

6.1 This report has been written with contributions from all Children's Trust partners and circulated to the Board. It will be disseminated to all partners, the Health and Wellbeing Board and Reading Local Safeguarding Children Board.

7. EQUALITY IMPACT ASSESSMENT

7.1 The CYPP has been written to ensure a positive differential impact on racial groups, gender, people with disabilities, people of a particular sexual orientation, people due to their age and people due to their religious belief. The priorities and policies within the CYPP aim to redress current inequalities and further information can be found in section 2 of the CYPP where the key needs, achievements so far and future aims for these priorities are presented.

8. LEGAL IMPLICATIONS

8.1 The Children Act 2004 and Children and Young People's Plan Guidance (2009) had placed a requirement that a Children and Young People's Plan should be written by the local authority, in conjunction with the Children's Trust.

8.2 In July 2010, the Government announced the repeal of the Children's Trust statutory guidance. The Department for Education had indicated that this did not mean that Trusts were being abolished and the duty on partners to cooperate would continue to apply. However, it would no longer be a statutory responsibility to produce a Children and Young People's Plan (CYPP).

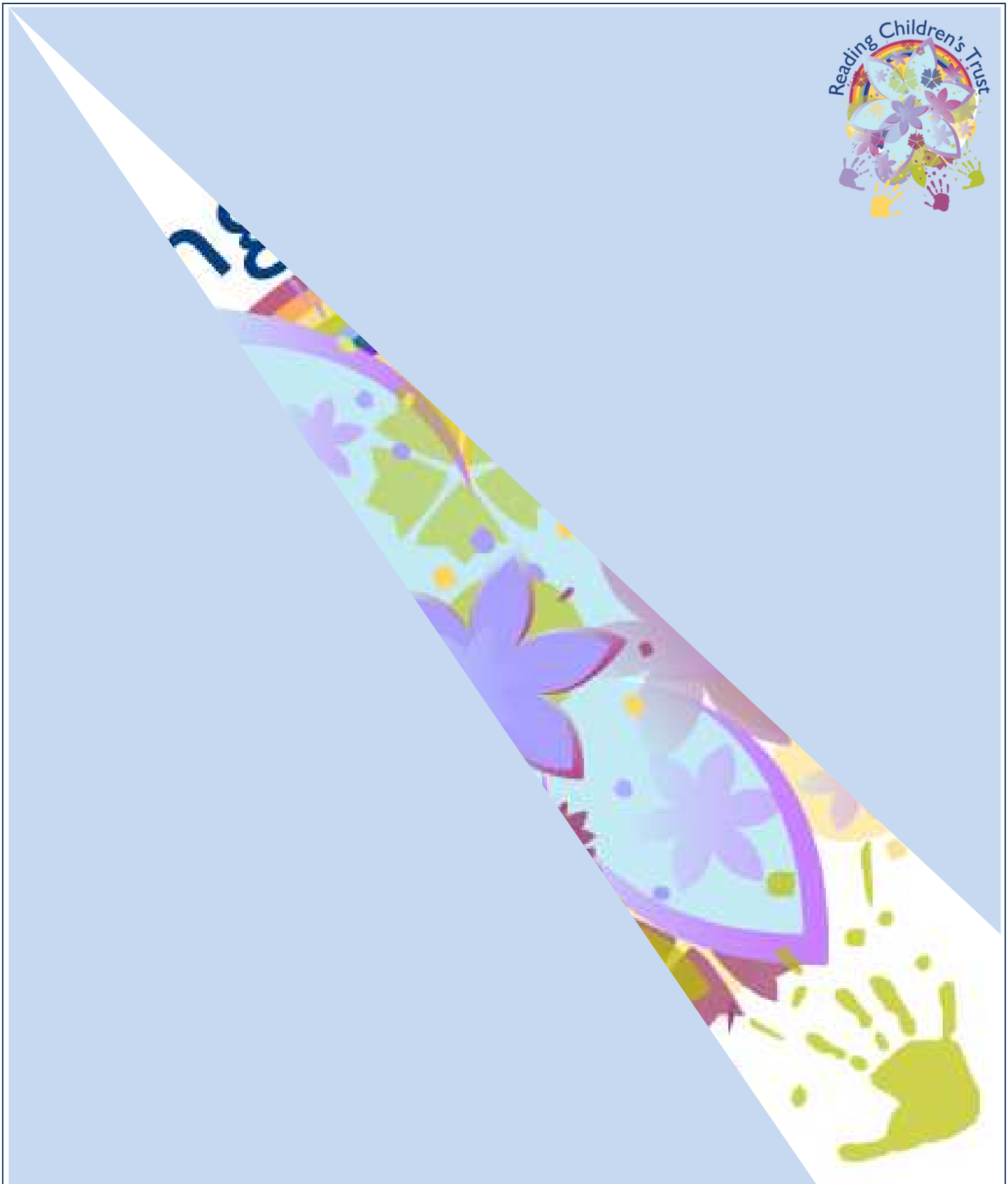
9. FINANCIAL IMPLICATIONS

9.1 The delivery of the activities covered by the plan is funded by budgets controlled and planned by the respective partners. There is no additional cost of delivery though accepting this plan.

9.2 The monitoring of the plan will be carried out through the regular CT meetings which are serviced by the existing business manager and administrator. There is no increase in those costs as a result of accepting this plan.

10. BACKGROUND PAPERS

10.1 Children Act 2004
10.2 Reading Children and Young People's Plan 2011-2014



Children and Young People's Plan 2015-2018

Contents

Foreword

We are pleased to introduce our latest Children and Young People's Plan which sets out how we will deliver on priority areas identified as issues for children and families in Reading.

The purpose of the Children's Trust is to consult with and bring all partners with a role in improving outcomes for children together to agree a common strategy on how they will co-operate to improve children's wellbeing and to help embed partnership working in the partners' routine delivery of their own functions. It also provides a strategic framework within which partners can commission services together. Delivering the strategy, the Children & Young People's Plan (CYPP), is the responsibility of the partners, both individually and together.

In 2010, the Government withdrew the statutory Children's Trust guidance, along with the requirement on the Trust to produce a CYPP. All current Children's Trust partners in Reading were consulted regarding the value they place on Reading's Trust and CYPP, and all recognised their additional value and committed to supporting both.

Although the Children's Trust has identified priority areas of focus (see page 6) it also closely aligns to the key theme of the Council Corporate Plan – Narrowing the Gap – and two of its service priorities – safeguarding and early help.

This plan has been agreed by all partners representing Reading's Children's Trust Board, and represents a shared commitment to helping all children and young people to achieve their full potential. By working in partnership, we are better able to provide the support and services required to enable all Reading's children to achieve our vision.

Councillor Jan Gavin
Chair, Reading Children's Trust

Local context – Narrowing the Gap

Reading is a vibrant multi-cultural town: the second most ethnically diverse in the South East outside London. Reading has a history of good community relations and is a place where diversity and cohesion are celebrated and embraced. However, the pace of change has been rapid and Reading's outstanding economic success has bypassed some of its residents. Reading's most deprived areas sit next to communities which prosper. Reading's economy is well placed for the future but we need to continue to recognise the inequalities that some people in our town face to ensure that Reading's recovery from recession means better prospects for all its residents.

Our population has grown by 9% over the last 10 years and Reading is an increasingly diverse place. 49.4% of the school population belongs to an ethnic group other than White British compared to 25% in England overall. An increasing proportion is bilingual with 30% of pupils speaking English as an additional language, with 150 first languages in the area. 18.8% of children in Reading live in poverty and 30% of Reading pupils are eligible for pupil premium, the Government grant to school to counter disadvantage.

Educational attainment levels for children who live in poverty and children from some ethnic minorities are lower than the average for Reading. Closing the gap in attainment for vulnerable and disadvantaged children is vital to ensure equality of life chances later on. We want to ensure that all children and young people access educational provision, and that there is regular school attendance of all pupils, in order that all young people access the very best education opportunities available to them.

We have higher than the regional average for young people not in education, employment or training. Particular 'at risk' groups include young offenders, teenage parents, and young people with learning difficulties and disabilities. Through our City Deal programme called 'Elevate' we will provide more job and training opportunities for 16-24 year olds and a joined-up offer of support across agencies.

Vision

Our challenge as a partnership is to enable all children and young people to achieve their potential and where nobody gets left behind.

Our aim is to create a positive and ambitious environment for Reading children and young people so that they:

- are happy, healthy, safe and coping with change and challenge
- are enthusiastic and skilled learners
- value themselves and others

Working together

We all have a responsibility to work together to ensure the children and young people of Reading can achieve and flourish to the best of their abilities. Importantly, this responsibility starts with families and communities, and we will do our best to support them when needed; only stepping in with specific services when required.

The Children's Trust works closely with the Local Safeguarding Children Board and the Reading Health and Wellbeing Board. In 2014 a protocol between the three Boards was established to ensure a shared commitment to a strategic approach to understanding needs, develop a joined up approach to understanding the effectiveness of services and identifying priorities for change, and provide constructive challenge to one another and partners. A copy of this protocol can be found on our website: www.reading2020.org.uk/childrens-trust/

Values for the Children's Trust

- Respecting the autonomy of individual partners
- Promoting excellence in individual agencies and across the partnership
- Taking a shared responsibility
- Valuing and sharing innovation
- Dealing with difficulties through dialogue and mutual respect
- Seeking to develop the workforce in all agencies and organisations
- Promoting equality, celebrating diversity and maximising life chances for disadvantaged individuals, groups and communities
- Collaborating to address the needs and interests of all children and young people

This means:

- We will share data and performance information
- We will work together to ensure that there is a systematic approach to reducing inequalities for disadvantaged individuals, groups and communities
- We will seek to develop the workforce together
- We will foster partnerships and critical friendships which promote support and challenge across the Children's Trust
- We will work holistically with the whole family to meet their needs in partnership with each other

Each member must have sufficient delegated authority from their host organisation to enable them to support the functioning of the Trust in a meaningful way. Each member is expected, and should feel able, to take part in discussions at Trust Board meetings.

Reading Children's Trust Board Membership

Representatives from the following organisations currently make up our Board:

Reading Borough Council
Thames Valley Probation Service
Berkshire Healthcare Foundation Trust
South Reading Clinical Commissioning Group
North & West Reading Clinical Commissioning Group
Reading Children's & Voluntary Youth Services
Royal Berkshire Fire & Rescue Service
Reading Youth Cabinet
Thames Valley Police
Reading College
Adviza
Schools and Governors

Reading Youth Cabinet

Reading Youth Cabinet are a group of elected representatives for the young people of Reading, who campaign on issues that have been highlighted both locally and nationally. We also make a difference by voicing the opinions of young people to the decision makers. This includes membership of the Children's Trust where we are active participants at meetings.

The Overall aims of the Reading Youth Cabinet 2015

This year the cabinet not only has aims within their campaigns but also have aims as a whole cabinet. They are:

- To support the work of the Local Safeguarding Children Board (LSCB) and the Children's Trust Board.
- To present and seek support for their campaigns at Full Council
- To develop closer links with UKYP (UK Youth Parliament) and support their national campaigns

The campaigns for Reading Youth Cabinet 2015

After a vote, the two campaigns that gained the most support were:

Mental Health – this campaign is a continuation of campaigns from 2012, 2013 and 2014 and one which mirrors one of the UKYP's main campaigns. This year the Youth Cabinet hope to progress the work and ensure that the "Treaty of Mental Health" is developed and expanded.

Furthering the push for more mental health education in schools, the Youth Cabinet is this year hoping to:

- Work with schools to develop a guide for 'best practice' in mental health support and education
- Create a network of 'mental health champions', representing schools across Reading, who meet to continuously review, develop and implement the 'best practice'
- Present the campaign to full council by the end of the year to gain support
- To produce a survey, to be carried out at two points in the year, that will gauge the views and feelings of young people and teachers on mental health support and education in schools.

Improving PSHE (Personal, Social and Health Education) – this was the overarching theme for last year's campaigns which included mental health, child abuse and Your future Your way. This year the Youth Cabinet has decided to have improving PSHE as a specific campaign based on what is seen as a growing need to re-evaluate the delivery of PSHE in schools.

Making PSHE more prominent and including young people in its planning and delivery.
This campaign centers on the view that PSHE and its content, style and nature of delivery, doesn't meet the evolving needs of young people. The Youth Cabinet is proposing to:

- Produce and distribute a survey that seeks to investigate the current perceptions of PSHE in schools.
- Encourage schools to more consistently include young people in the planning and delivery of PSHE, including young people trained to deliver PSHE in their schools and PSHE content to be decided on by young people and differentiated by year group.
- Develop the range of topics that PSHE covers and to create and collect a set of resources that schools can use in their delivery.

Children's Trust Priorities

A crucial challenge is to ensure Reading children and young people grow up in a positive and ambitious environment, and in particular to ensure all children and young people are safe, that we intervene early to support their families and that we help children, young people and adult learners learn in a way that secures their future economic success. These are the three key strands in this plan and form our priorities.

However, the CYPP cannot be read in isolation as it is intrinsically linked to other key strategies and plans either written, or in development. These are listed below.

Priority 1 - Having the best start in life and throughout

- Ensure that children and young people are empowered and informed to make positive life choices
- Enable children and young people to build emotional wellbeing and improve health
- Work to ensure that those using our services have as positive an experience as possible and are able to influence future service delivery
- All young people have access to an equitable universal offer across the area.

Focusing on prevention is key to improving outcomes in later life (and is more cost effective). The partners that make up the Children's Trust commission and provide a range of universal services, which play a vital role in identifying and addressing children and young people's additional needs at an early stage, intervening early and providing targeted support when extra help is needed. In particular community, voluntary and universal services, like mainstream schools have a vital role in early intervention and meeting a range of needs at the earliest point possible.

Links to:

- RBC Corporate Plan
- Early Help Strategy
- Health and Wellbeing Strategy
- Tackling Poverty Strategy
- Healthy Weight Strategy
- Berkshire Health Strategy for Looked After Children and Young People 2012 – 2015
- Maternity action plan
- CAMHs position paper- Berkshire West CCGs 2014

Priority 2 - Learning and employment

- All children and young people have a fair and equal chance to achieve, and have access to information to make informed decisions about their future, regardless of heritage, income or disability

We want all children to enjoy their education and achieve the best results they can. It is then vital that they have a range of access routes to employment.

Links to:
- RBC Corporate Plan
- Raising Achievement Strategy

Priority 3 - Keeping children safe

- Protect and safeguard ALL children and young people and in particular those that need our care. This includes protection from others (in particular, domestic abuse, sexual exploitation, on-line abuse and cultural abuse) and protection from harm they may cause themselves (in particular, self harming)

We will work with Reading Safeguarding Children Board (RSCB) to ensure that all agencies work together to protect and safeguard children. Both boards will continue to ensure that safeguarding is everybody's business, with a particular focus on key vulnerable groups and risk issues for Reading, such as domestic violence, neglect and child sexual exploitation.

Links to:
- RBC Corporate Plan
- LSCB Business Plan
- LSCB Child Sexual Exploitation Strategy
- Domestic Abuse Strategy
- RBC Neglect Strategy

How the priorities will be delivered

The following pages detail our current position in relation to each priority, what will happen over the next year and how we will know we are making a difference.

Having the best start in life and throughout

What do we know?

- 2300 children in Reading live in poverty. This has a significant impact on all aspects of their lives from birth onwards and the risks of poverty are highest for certain ethnic groups
- Although improving, there is a high number of children in Reading not attending 2 year old Health Reviews. Resulting in more than half of Reading's children not having health and development issues beginning to be addressed at an early stage, especially around healthy eating and speech and language issues
- Good progress has been made against the early years foundation stage profile, with 64% of children reaching a good level of development by the end of the reception year. However certain groups of children are still underperforming and this remains a focus
- 68% of children eligible do access the two year old entitlement which has significantly improved through 2014
- There is an increased demand on local mental health services and the complexity of cases is increasing
- One in three children in Reading are obese or overweight by then time they leave Primary School
- The national programme to increase numbers of Health Visitors has led to an increase locally which allows us to have greater integration of services at local level.
- There is a drop off in children receiving their second dose of the MMR vaccine leaving them vulnerable to contracting these dangerous diseases.
- Although 78.5% mothers start to breastfeed after birth, this drops to only 55% eight weeks later
- Although services do regularly ask children and young people about their experience of a service, and this has been used to shape service development and improvement, we need to ensure this is routine

Examples of current activity from across the partnership:

Training opportunities are offered to schools, voluntary sector and public sector staff to improve their understanding of children's emotional and mental health

We provide essential counselling opportunities for young people in Reading which helps to improve young people's emotional health and wellbeing and reduce unnecessary referrals into Tier 3 CAMHS

A mental Health guide for young people has been developed with the Youth Cabinet and distributed to all Reading Secondary Schools, and those with large a proportion of Reading pupils

Availability of highly specialist CAMHs services in Berkshire is being improved and extended

Our voluntary sector and Local Authority run Nurseries and Pre-Schools provide essential child-care and early education for children under the age of 4 in Reading, and make a vital contribution to improving a child's early life chances. In turn, this provides parents with the opportunity to return to work. Many of these settings also provide valuable apprenticeship, training and work experience opportunities for young people wanting to pursue a career in child care

A wide range of support is available to support to families who have children with Special Educational Needs and Disabilities

An investment programme is in place to ensure free 2 year old places for those that want it

In our children's centres we help families with young children attend midwifery appointments, health visiting checks and speech and language drop-in sessions. Education and smoking awareness sessions are also available

We run a range of parenting programmes in the community which help parents to be more confident and effective on their caring role

Families are supported via voluntary sector organisations providing home-visiting support and advice services, including information on housing and benefits

Voluntary sector Parent and Toddler Groups help to promote attendance at 2 year Health Reviews in Reading and Breastfeeding Network and the National Childbirth Trust (NCT) provide breastfeeding support for parents, through trained volunteers and peer supporters

Let's Get Going - Healthy Eating and Physical Activity course provided for school children who are overweight / obese

Our youth work in communities and schools offers positive activities, access to advice and guidance and learning opportunities

Juice points - Condom distribution and relationship advice for young people is offered through the Juice Points and C-Card scheme

Some of the things that will happen in the first year	Who
Increase attendance at 2 year Health Reviews in Reading to ensure that more families can access the support they need	BHFT
Increase the number of parents and children from vulnerable/target groups using children's centre services	Children's Services (RBC)
Increased investment in emotional and mental health services to provide enhanced specialist CAMHS services and reduce the number of children who needs escalate to crisis point	CCGs
Reduced waiting times for mental health services, with a greater focus on self-care, prevention, early identification and training of children's workforce	CCGs/BHFT/ RBC/Schools/ RCVYS
Perinatal mental health project will improve access to appropriate health services in the community and improve awareness in the workforce to ensure early identification of concerns and respond accordingly	Children's Services/ Public Health

The Health Visiting service will become the responsibility of the Local Authority and the forthcoming year will focus on ensuring the service continues its momentum of improving health outcomes for those most in need	Public Health
Develop a local media campaign that promotes the importance and benefits of 0-5's being up to date with all their primary vaccinations	Public Health
Work with key stakeholders (including BHFT, RBH Midwifery and Children's Centres) to increase opportunities for breastfeeding aligned with existing commissioned services (Breastfeeding Network and UNICEFs Baby Friendly initiative)	Public Health/ CCGs
Use the national child measurement programme to target support and interventions in schools and ensure that staff can refer children into appropriate services	Public Health
Development of the FireFit programme which employs the positive, physically-active brand of the Fire Service to engage with overweight young people and their families, as a means of supporting them to make sustainable lifestyle changes, that will improve their health and fitness into the long-term.	RBFRS
Implementation of an online tool from CAMHS to encourage young people to co-write, develop and evaluate their own care plans	BHFT
Increase development, awareness and use of applications designed for young people to be able to feedback on services, such as the MOMO and self harm apps	Children's Services/BHFT/ Public Health
An increase in the number of Tier 4 CAMHs in-patient beds available in Berkshire	BHFT/NHS England

How will we know we are making a difference?

- Reduce the number of children in low income families
- Improvement in the CAT outcome star progress to work indicator
- Increased attendance at 2 year Health Reviews
- Reduction in the number of re-referrals to Children's Action Teams
- Improved breastfeeding figures
- Reduction in levels of obesity – Reception and Year 6
- Improved vaccination figures
- Children will be ready, prepared and fit for school
- Number of professionals trained in mental health awareness
- Percentage of parent evaluations showing a positive change recorded between pre and post scoring as against the total number of parents completing the programme
- Reduction in BHFT CAMHS waiting times

Learning and employment

What do we know?

- The general educational quality in Reading is considered below the England average. At Key Stages 1 and 2 results have fallen, and this is a particular issue for certain groups of children – those on pupil premium, particular ethnic groups, looked after children (LAC) and those with special educational needs (SEN).
- Reading has a higher proportion of pupils eligible for pupil premium than the South East and other Berkshire authorities, and this group tends to do less well
- On average, attainment by young people from Black and Mixed race heritage at Key Stage 2 is lower than their peers and this gap continues to GCSE level
- Reading has a significant number of young people who are NEET (Not in Employment, Education or Training). Additionally too many children with statements of SEN/EHCP are being temporarily or permanently excluded from mainstream and special schools compared with our statistical neighbours
- More schools in Reading need to be rated as 'good' or better by Ofsted to ensure a consistently good level of education wherever you live
- Over the past couple of academic years, exclusions have reduced for both Primary and Secondary age groups, however, the exclusion of vulnerable groups (SEN; LAC; and some BME groups) remains a concern
- Similarly, attendance rates at Primary and Secondary levels have shown some improvement, including those who are persistently absent, but specific focus remains on vulnerable groups where additional support is required
- Not enough young people are taking up apprenticeship opportunities, partly due to lack of demand and party due to lack of availability.
- A local offer has been established in Reading to help families obtain information regarding services that are available to them to support them with regard to SEN

Examples of current activity from across the partnership:

Mentoring support and work experience placements are available for young people to assist them to access education, employment or training opportunities, through the Elevate Reading Programme

Voluntary organisations provide specialist support to assist young people with Special Educational Needs to access education, employment or training opportunities

Volunteering opportunities for young people are available

The Elevate community and learning hub is open at Central Library providing improved information, advice and guidance for job and training opportunities for 16-24 year olds

Reading Primary and Secondary Schools have collaborated to improve Science, Technology, Engineering and Maths (STEM) teaching, which included a month long project with the Bloodhound Project Team (World Land Speed Record attempt)

A system wide review is underway involving pupils, schools, Local Authority and the community, to raise the attainment and inclusion of children with black heritage

A School Partnership Advisor has been appointed with specific responsibility for leading the work to increase the effectiveness of the pupil premium in all schools

We have ensured every child has a school pace for September 2015 and beyond. We are building 2520 additional primary school places through a £61million capital programme and with 3 leading groups we will deliver 1 primary and 2 secondary free schools

Trained volunteers provide reading support for primary-aged children in schools

Safety education lessons are offered to every state and independent school - key messages target fire safety, driver and passenger safety (road traffic collision reduction) and hoax calls. Youth groups (including Brownies and Scouts) receive information on fire safety contained in their organisations programme and may visit a Station to find out about the firefighter role

Some of the things that will happen in the first year	Who
Deliver the City Deal Elevate to provide more coordinated easy to access information, advice and guidance (IAG); jobs; apprenticeships; work experience; mentoring and training opportunities for 16-24 year olds. Including a new employer engagement service to broker opportunities and support employers, including education for employers on opportunities for taking on young people in the work place	Elevate Group Reading
Elevate Programme for 16-24 year olds will include specific activity to support lone parents, those with learning difficulties, targeted outreach in wards of high unemployment and with a focus on those most disadvantaged. Plus increased outreach activity to engage young people who are 'not known' and not participating, working with and through the voluntary sector and New Directions with links and services out in the community.	Elevate Group Reading
Provide improved customer journey for young people from NEET to EET, including web site, self-help toolkit, IAG and joined up range of provider services under the Elevate brand with a no wrong door approach and seamless referral mechanism	Elevate Group Reading
A new Raising Attainment Strategy 2015/18 will be consulted on and launched in June 2015	RBC
Support schools to further improve their standards when they need help	RBC
We will prosecute families who do not ensure their children are attending school, including those taking holidays in term time	RBC
Support for schools for initiatives to celebrate and promote good and improving attendance	RBC

Development of two programmes to support young people at school. FireBreak involves firefighters working with cohorts of young people who may be getting in trouble at school and/or with the police, or providing an experience for young people not in education, employment or training. FireEd recruits a firefighter into the role of School Fire Liaison Officer (SFLO) by staff and children at the school in which they will work. The SFLO's remit is broad, and can involve: working to raise aspiration and attainment; working with pupils students who are not well engaged with education; reducing risk in the lives of the student population; and improving the health and fitness of all those in the school community.	RBFRS
Effectively use data to focus on vulnerable pupils to allow us to offer appropriate support, signposting or challenge to families and schools leading to improved attendance and behaviour	RBC
Reduce the number of children with complex needs placed in residential provision out of county by working in partnership with neighbouring authorities to provide local solutions	RBC/BHFT
Schools and the Local Authority are developing a new procedure for allocating additional funding to mainstream schools to support those pupil who are considered to have exceptional needs, based on a school cluster moderating process and is designed to make the allocation of additional resources both fairer and speedier	RBC/Schools
As part of the educational reforms the Local Authority has met the requirements for developing an Education Health and Care Plan (EHCP) and is required to embed this over three years. This process will enable families to become the authors of their child's EHCP. This allows the young person to identify their aspirations, the outcomes to meet the aspirations and the provision needed to meet the outcomes	RBC
We will develop a system for tracking the progress of young people with special educational needs, up to the age of 25	RBC

How will we know we are making a difference?

- Improved Key Stage 2 results generally and for particular groups
- Improved GSCE results for particular groups
- There are enough school places for all children and young people in Reading
- Increase the number of schools rated as 'good' or better by Ofsted
- Greater number of work experience placements, apprenticeships and sustained employment for 16-24 year olds
- Increase in the percentage of young people 16-19 (up to 25 for young people with learning difficulties/disabilities) who are known to be in Education, Employment or Training
- Reduction in young people claiming Job Seekers Allowance
- Reduction in exclusion rates

Keeping children safe

What do we know?

- There continues to be an increase in referrals to Children's Social Care
- The numbers of children subject to protection plans, care proceedings and looked after children are still too high
- We have delivered phase one of the Troubled Families programme and have a target in phase two to improve outcomes for 1220 families that are being left behind from 2015 – 2020
- We need to improve the number of medicals for looked after children completed on time
- Child Sexual Exploitation (CSE) is a known risk for the children and young people of Reading
- We have a good rate of CAFs (Common Assessment Framework) per 10,000 children, in comparison to other South East Local Authorities, with 83 CAFs per 10,000 children
- We have a high rate of domestic abuse that we know impacts negatively on children's emotional health and wellbeing
- The Signs of Safety model has been successfully introduced across Children's Services and with partner agencies, including in the areas of child protection and looked after children

Examples of current activity from across the partnership:

Every contact to our Multi-Agency Safeguarding Hub is screened for child protection concerns with partners to improve our decision making and outcomes for children's safety

Support for survivors of abuse (domestic, emotional or sexual), and their families, is provided by a range of voluntary sector organisations. This includes one-to-one or group support, refuge, preventative work and raising awareness

Reading Safeguarding Children Board alongside RCVYS deliver safeguarding training at various levels and over a range of subjects for the entire children's workforce

We provide age-appropriate drug and alcohol education for children and young people in schools and other group environments, helping young people make informed lifestyle choices

We use the Outcomes Star with families to help identify key areas of change that they want to work on to improve the lives of their children

We identify and discuss in multi-agency meetings high risk children, young people and families where domestic abuse and CSE are concerned

Every child with a Children's Action Team keyworker will have a completed CAF to provide a multi-agency assessment of the child and their family to support a plan of interventions

Voluntary sector organisations directly support and provide first aid to young people and adults in Reading's night-time economy

Some of the things that will happen in the first year	Who
Renew and improve use of the Strengths and Difficulties Questionnaire (emotional health and wellbeing tool) to ensure is it fit for purpose and how to make the best use of it. Its primary focus is looked after children but it could be useful for any vulnerable children (8 years+)	Public Health/ Children's Services
Implement phase 2 of the Troubled Families programme with priorities to meet locally agreed needs	Children's Services
Implementation of the CSE action plan	CSE Group
Produce a CSE and Missing Toolkit for use by all agencies that includes an agreed screening tool and referral processes	Children's Services
Introduce a Peer mentoring scheme to schools to involve learners in raising awareness of CSE and supporting pupils in efforts to keep safe	Children's Services
Develop support programmes for parents, carers, families and victims of CSE	CSE Champions Group
Implement a clause in the quality schedule in the contract with BHFT to ensure the rates of medicals for looked after children completed on time improve	CCG/BHFT
Undertake a wider review and reshape of early help for children and families, with a view to developing a single access point for services	Children's Services
Implementing, in partnership with the Police, a new multi-agency safeguarding hub (MASH), to allow a wider range of information about a family to inform our response to referrals, minimising harm to vulnerable children and young people.	MASH Steering Group
Implement the Reading's Domestic Abuse Strategy to increase prevention and identification of Domestic Abuse, and improve the support for victims to become survivors.	Domestic Abuse Strategy Group

How will we know we are making a difference?

- Reduction in the number of re-referrals to Children's Social Care
- Reduction in the number of children on a CP Plan for a second or subsequent time
- Increase in the number of LAC Medicals completed on time
- Number of Single Assessments completed on time
- Referrals to Children's Social Care for CSE
- Reduction in levels of teenage pregnancy
- Reduce the number of First Time Entrants into the Criminal justice system per 100,000
- Reduced number of repeat contacts with to Children's Social Care with DA as the reason
- Less than 10% of closed CAT cases that are referred back to Children's Social Care

Glossary

Abbreviation	Explanation
ACY	Academic Year
ASD	Autistic Spectrum Disorders
BESD	Behaviour, Emotional and Social Difficulties
BME	Black and Minority Ethnic
CAF	Common Assessment Framework
CAMHS	Child and Adolescent Mental Health Service
CAT	Children's Action Team
CIC	Children In Care
CIN	Children In Need
CPP	Child Protection Plans
CYP	Children and Young People
CYPP	Children and Young People's Plan
DAAT	Drug and Alcohol Team
DA	Domestic Abuse
EET	Education, Employment and Training
EWO	Education Welfare Officer
EYFS	Early Years Foundation Stage
IAG	Information Advice and Guidance
JCP	Job Centre Plus
JSNA	Joint Strategic Needs Assessment
KS	Key Stage
LA	Local Authority
LAC	Looked After Children
LDD	Learning Difficulties and/or Disabilities
LSCB	Local Safeguarding Children's Board
LSP	Local Strategic Partnership
MAPPA	Multi-Agency Public Protection Arrangements
MARAC	Multi-Agency Risk Assessment Conferencing
MASH	Multi Agency Safeguarding Hub
MYPs	Members of the Youth Parliament
NEET	Not in Education, Employment or Training
NHS	National Health Service
OFSTED	Office For Standards in Education
PEP	Personal Education Plan
PSHE	Personal, Social and Health Education
RBC	Reading Borough Council
RBH	Royal Berkshire Hospital
RCVYS	Reading Children's & Voluntary Youth Services
SATs	Standard Assessment Tests
SDQ	Strengths and Difficulties Questionnaires
SEN	Special Education Needs
STEM	Science, Maths, Engineering & Technology
TAC	Team around the Child
TP	Teenage Pregnancy
UKYP	UK Youth Parliament
VCS	Voluntary and Community Sector
YOS	Youth Offending Service
YP	Young People

Further Information

For further information regarding the Children's Trust and the Children & Young People's Plan please visit the website www.reading2020.org.uk/childrens-trust/.